| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 295020 | A. Building<br>B. Wing | 12/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Rosewood Rehabilitation Center | 2045 Silverada Blvd<br>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) |
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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to1) ensure medications were not stored in a resident room for one unsampled resident (Resident #91), 2) monitor and record medication refrigerator temperatures in 1 of 2 medication storage rooms, 3) remove expired medications from 1 of 2 medication rooms, 4) label and properly store an unused insulin pen, 5) store insulin pens in separate sections or individual containers for each resident in 2 of 2 inspected medication carts, 6) ensure a glucometer was not stored in the same section of the medication cart as used insulin pens, and 7) store a used insulin pen appropriately, as it was placed on top of lancets. This deficient practice had the potential to result in medication errors, compromised infection control, and increased risk of harm to residents due to improper medication handling and storage.Findings include: Medications in resident roomsResident #91Resident #91 was admitted to the facility on [DATE], with diagnoses including fibromyalgia, chronic pain syndrome, and muscle weakness (generalized).A physician's order dated 03/22/2025, documented Tylenol 325 milligram (mg) tablets, give two tablets by mouth every four hours as needed for an oral temperature greater than 100 degrees Fahrenheit (F) or a rectal temperature greater than 101 degrees F.A physician's order dated 03/22/2025, documented Tylenol 325 mg tablets, give two tablets by mouth every four hours as needed for mild pain.On 12/08/2025 at 11:58 AM, resident #91 was sitting in a chair in the resident's room. A bottle of Tylenol 500 mg tablets, extra strength, 325 tablet count, was sitting on Resident #91's nightstand. A Licensed Practical Nurse (LPN1) located a tube of Voltaren, diclofenac sodium 1 percent (%) topical gel in the resident's nightstand drawer. The resident could not tell the nurse when the resident last took Tylenol. The nurse verbalized the family had brought in medications in the past and continued to bring in medications.On 12/08/2025 at 12:01 PM, LPN1 confirmed the resident did not have orders to keep medications in the resident's room to self-administer and confirmed residents were not allowed to store medication in resident rooms.On 12/11/2025 at 10:26 AM, one tube of Voltaren, diclofenac sodium 1% topical gel and a bottle of multi-vitamins, 40 count was in Resident #91's room in a bin on top of the resident's nightstand.On 12/11/2025 at 10:28 AM, LPN2 confirmed a tube of Voltaren, and a bottle of multivitamins were found in a bin on top of Resident #91's nightstand and should not be in the resident's room. The LPN verbalized the resident was at risk of over medicating and/or the medications could result in an adverse reaction when mixed with the resident's other prescribed medications. The LPN verbalized concern that other residents could access and take the medications.On 12/11/2025 at 3:49 PM, the Interim Director of Nursing (IDON) confirmed residents were not supposed to keep medications in resident rooms. The IDON explained the IDON spoke with the resident's family member following the second time medications were found in the resident's room on 12/08/2025 and 12/11/2025.The IDON explained the facility could ask the family member for consent to search any bags brought into the facility and verbalized the family member had the right to refuse. The IDON explained when residents were not allowed to keep items brought in from home, it did not create a home-like environment. The IDON acknowledge it was the facility's responsibility to<br>(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 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | keep residents safe and confirmed it was a safety concern when a resident kept medications in the resident's room.On 12/11/2025 at 3:54 PM, the IDON verbalized the concerns were Resident #91 could overdose on too much Tylenol, other residents had access to the medications, and the risk of interactions with other medications and disease processes such as liver issues.The facility policy titled Storage and Expiration Dating of Medications and Biologicals revised 06/03/2025, documented the facility ensured all medications, including treatment items, were secured in a locked cabinet/cart or locked in a medication room that was inaccessible by residents and visitors. Medication refrigeration temperatures (Station B)On 12/11/2025 at 10:50 AM, the temperature log for the Station B medication refrigerator did not include a recorded temperature check each day, for each shift as follows:July 2025:-A temperature check was not recorded during day shift for 19 of 31 days.-A temperature check was not recorded during night shift for 20 of 31 nights.August 2025:-A temperature check was not recorded during day shift for 7 of 31 days.-A temperature check was not recorded during night shift for 2 of 31 nights.September and October 2025:-The facility did not provide a temperature log for the Station B medication refrigerator for the months of September and October 2025.November 2025:-The facility did not provide a day shift temperature for the Station B medication refrigerator.-A temperature check was not recorded during night shift for 20 of 30 nights.December 2025:-A temperature check was not recorded during day shift for 5 of 11 day shifts.-The facility did not provide a night shift temperature log for the Station B medication refrigerator.On 12/11/2025 at 10:54 AM, the Assistant Director of Nursing (ADON) verbalized the temperature of the medication refrigerator was to be assessed and recorded twice each day/one time per shift. The ADON confirmed the log sheets for the B Station Medication room were incomplete and should have been documented once each shift. The ADON explained maintaining the temperature of the refrigerator was important because some medications were sensitive to temperatures and strength of the medication could be altered if the medication became too warm or too cold.The facility policy titled Storage and Expiration Dating of Medications and Biologicals revised 06/03/2025, documented the facility stored all medications and biologicals at the appropriate temperatures according to the United States Pharmacopeia (USP) guidelines for temperature ranges and manufacturers guidance. The facility monitored the temperature of medication storage areas at least one time per day and twice per day where vaccines were stored. Refrigerators were to be maintained from 36-46 degrees F.Expired medications (Station B)On 12/11/2025 at 11:11 AM, one promethazine 25 mg suppository with an expiration date of 05/2025, was located in the Station B medication room refrigerator. The ADON confirmed the medication was expired and should have been removed from the medication storage room. The ADON explained expired medications could become either stronger or weaker when past the expiration date and alter the intended strength of the medication.The facility policy titled Storage and Expiration Dating of Medications and Biologicals revised 06/03/2025, documented the facility ensured expired medications were stored separate from other medication until destroyed or returned to the pharmacy.Unlabeled insulin pen (Station B)On 12/11/2025 at 1:57 PM, one un-labeled Humalog (insulin lispro) pen (pen), a fast-acting insulin, was located in the B hall back medication cart. The pen had not been used. The ADON confirmed the pen should not have been stored in the medication cart unlabeled and confirmed prior to first use, the insulin pen was to be stored in the medication refrigerator. The ADON could not determine which resident the pen belonged to.The facility policy titled Storage and Expiration Dating of Medications and Biologicals revised 06/03/2025, documented the facility destroyed medications with missing labels or cautionary instructions.Insulin pens and glucometer (Station A, back medication cart)On 12/11/2025 at 2:30 PM, insulin pens and glucometers were stored in the Station A back medication cart as follows:-One Humalog (lispro) insulin pen, used, was lying on top of lancets being stored in the cart for use throughout Station A. There was not a protective barrier between the used insulin pen and the unused lancets.-Eight Humalog (insulin lispro) pens, and four Lantus (insulin glargine) pens were stored in the same compartment of the medication cart without a barrier, such as a clear plastic bag, between the pens. The pens belonged to seven<br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | different residents.-One glucometer was being stored in the same compartment/section of the medication cart as the used insulin pens and without a protective barrier.On 12/11/2025 at 2:35 PM, the ADON confirmed the insulin pens were not being properly stored and should have been stored in separate compartments, or clear plastic bags for each resident, and confirmed the glucometer should not have been stored with the insulin pens. The concern was an increased risk of infection due to cross contamination and an increased risk of using the wrong pen on the wrong resident.The facility's medication storage and infection control policies did not include guidance for the appropriate storage of insulin pens to prevent cross contamination and spread of infections. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**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 1) residents on Enhanced Barrier Precautions (EBP) had bins placed inside the resident's room, near the door, for the disposal of used personal protective equipment (PPE), and staff received the training and education necessary to properly dispose of PPE after use, 2) Enhanced Barrier Precautions were implemented for a resident with an indwelling medical device for one unsampled resident (Resident #118) and 3) trends in infections in the facility were investigated for potential causes contributing to the trend, and interventions to control and prevent infections were implemented based on the outcome of the investigation. This deficient practice had the potential to spread infection, including infections with multi-drug-resistant organisms (MDROs), throughout the facility to other residents. Findings include:<br><br>Disposal of PPE<br><br>On 12/11/2025 at 12:20 PM, a Licensed Practical Nurse (LPN) was in a resident room designated for Enhanced Barrier Precautions (EBP). The LPN was wearing a cloth gown and disposable gloves.<br><br>On 12/11/2025 at 12:39 PM, the LPN administered the resident's medications, assessed the resident for bowel sounds, flushed the resident's gastric tube, and started enteral nutrition. Upon leaving the room, the LPN removed the cloth gown and placed the gown on the floor near the door, next to a trash can. The LPN removed the disposable gloves in the hallway and put the gloves into a trash bin on the medication cart.<br><br>On 12/11/2025 at 1:22 PM, the gown remained on the floor in the resident's room. The Administrator confirmed the cloth gown was lying on the floor and should have been placed in a clear trash bag and put in the laundry hamper. There was not a designated bin, or trash can in the room for staff to discard of PPE after use.<br><br>On 12/11/2025 at 1:31 PM, the IP confirmed the facility was not providing dedicated bins for the disposal of PPE in rooms with EBP. The expectation was staff would place gloves in the trash inside the resident's room, and the cloth gowns would be placed in a clear plastic bag and put into the resident's hamper. The IP confirmed staff should not throw PPE on the floor and should not be removing gloves in the hallway and disposing of them in the trash receptacle on the medication cart. The IP confirmed the facility was not currently using dedicated bins for infection control in rooms with EBP. The IP verbalized the concern with PPE being improperly doffed and disposed of was the potential for the spread of an infection throughout the facility.<br><br>The facility policy titled Infection Prevention and Control Program (IPCP) revised on 04/2025, documented EBP required the use of gown and gloves during high-contact resident care activities due to the opportunity for the transfer of multi-drug-resistant organisms (MDROs) to staff hands and clothing with the potential to be transferred to residents or from resident to resident. High contact care activities include the care of indwelling medical devices. Implementation of EBPs included placing a trash can inside the resident room, near the exit for discarding PPE after removal and prior to exiting the room.<br><br>Implementation of Enhanced Barrier Precautions<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Resident #118<br><br>Resident #118 was admitted to the facility on [DATE], with a diagnosis of end stage renal disease.<br><br>On 12/08/2025 at 9:10 AM, during a tour of the facility Resident #118's room lacked signage indicating the resident was on EBP.<br><br>On 12/08/2025 at 12:59 PM, Resident #118 was lying in the resident's bed. The resident verbalized the resident went to dialysis three times per week. The resident had an implanted dialysis catheter in the resident's right upper chest.<br><br>A Progress Note dated 12/03/2025, documented Resident #118 had a Hemodialysis (HD) port to right chest and the dressing was clean and intact.<br><br>Resident #118's Care Plan documented the resident required hemodialysis due to renal failure. Interventions included checking and changing the access site dressing daily, monitoring/documenting/reporting any signs/symptoms of infection of the access site (redness, swelling, warmth, drainage) to the physician.<br><br>On 12/10/2025 at 11:16 AM, a Licensed Practical Nurse (LPN) verbalized the intent of EBP was to help prevent the transmission of infection and was to be used for residents with devices such as catheters, gastric tubes, and tracheostomies. Staff knew a resident was on EBP by receiving the information in report from the previous shift and by signage posted near the resident's door. The LPN confirmed the LPN was assigned to care for Resident #118 and verbalized the resident should be on EBP due to the resident having a dialysis catheter. The LPN confirmed Resident #118's room lacked signage indicating EBP was in place and verbalized the resident's chart (clinical record) lacked information related to EBP.<br><br>On 12/10/2025 at 11:36 AM, the Infection Preventionist (IP) verbalized EBP was used to help prevent the spread of Multi Drug-Resistant Organisms (MDROs) and would be implemented for residents who had implanted medical devices. The IP explained when EBP was implemented, an order would be placed in the resident's record, and it would be added to the resident's care plan. The IP verbalized the IP was unsure if EBP had been implemented for Resident #118 as the IP had not reviewed the resident's record.<br><br>On 12/10/2025 at 12:21 PM, the IP confirmed Resident #118 did not have EBP in place and should have been on EBP due to the presence of the dialysis catheter in the resident's upper chest. The IP confirmed the resident's record lacked an order and entry on the care plan and the resident's room lacked appropriate signage regarding EBP.<br><br>The facility policy titled Infection Prevention and Control Program (IPCP) Standard and Transmission-Based Precautions, dated 10/2022, documented EBP referred to the use of gowns and gloves during high-contact resident care activities which provided opportunities for indirect transfer of MDROs to staff and other residents. EBP was to be used for residents with wounds, indwelling medical devices, and MDRO infection or colonization and was intended to be in place for the duration of a resident's stay in the facility or until the resolution of the wound or discontinuation of the indwelling medical device.<br><br>Investigation of infection trends in the facility<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | The facility document titled Infection Prevention and Control Meeting Minutes, for review of October 2025, documented infection trends in the facility included increased Urinary Tract Infections (UTIs) and fungal infections.<br><br>The facility document titled Infection Prevention and Control Meeting Minutes, for review of November 2025, documented infection trends in the facility included UTIs and fungal infections.<br><br>On 12/11/2025 at 12:04 PM, the IP verbalized the purpose of the IP role in the facility was to facilitate the Infection Prevention and Control Program (IPCP) and provide education to staff on the facility's infection control policies. Infections within the facility were tracked using a monthly infection control tracking log. The IP verbalized the facility's current most frequent infections were UTIs and skin infections such as cellulitis and fungal infections. Interventions to address the increased infections included shower audits and offering residents oral fluids.<br><br>On 12/11/2025 at 12:35 PM, the IP verbalized shower audits were completed in November to investigate the increase in skin infections. While completing the audits, the IP found residents often refused showers. Certified Nursing Assistants (CNAs) were instructed to notify the resident's nurse when a resident refused a shower, the nurse would then ask the resident the reason for the refusal and offer a different type of bath. The IP explained the education was provided to staff verbally and the IP denied having documentation of the shower audits, education provided to staff, which staff were educated, when the education was provided, and any follow-up or outcomes afterward.<br><br>The IP recalled investigation of the increase in UTIs consisted of the IP completing a total of four observations of staff providing incontinence care to residents and the IP provided verbal education to one CNA. The IP denied any additional investigation occurred to determine factors which could have been contributing to the increase in UTIs in the facility and denied the intervention of offering fluids to residents was selected based on the outcome of an investigation. The IP denied having any documentation of observations of staff providing incontinence care, education provided to staff, which staff were educated, when the education was provided and any follow-up or outcomes afterward.<br><br>The facility policy titled Infection Prevention and Control Program, reviewed 04/2025, documented elements of the IPCP was to be carried out by the IP and consisted of coordination/oversight, surveillance, data analysis, and prevention of infection. Surveillance tools were used to recognize the occurrence of infections, record their number and frequency and detect outbreaks and epidemics. Under the infection control program the facility would investigate, control and prevent infections in the facility, decide what measures/interventions should be applied in individual circumstances, and maintain a record of incidence of infection and corrective action taken. |

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| F 0882<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review and document review, the facility failed to ensure the Infection Preventionist (IP) 1) provided education related to the Antibiotic Stewardship Program (ASP) to residents and residents' representatives/families and 2) carried out infection surveillance, investigation, prevention and control processes according to facility policies and Centers for Disease Control and Prevention (CDC) recommendations. This deficient practice had the potential to result in antibiotic-resistance and widespread transmission of infectious organisms throughout the facility.Findings include:Antibiotic Stewardship TrainingOn 12/11/2025 at 12:04 PM, the IP verbalized if an antibiotic was prescribed for a resident, the IP would visit the resident and provide education regarding the ASP. The IP would later call the resident's representative/family member to provide education regarding the ASP. The IP explained the education was provided verbally and denied the IP had documented evidence the IP provided the education.The IP confirmed education regarding the ASP was only provided to residents and representatives/families of residents who were prescribed an antibiotic. The IP explained the IP's plan going forward was to educate all residents and resident representatives/families regarding the ASP however, the education was not currently being provided.The facility policy titled Antibiotic Stewardship, reviewed 04/2025, documented the facility would implement an Antibiotic Stewardship Program (ASP) to promote appropriate use of antibiotics. Education opportunities as identified by the QAPI committee, should be provided for clinical staff as well as residents and their families on appropriate use of antibiotics.Implementation of infection control processesResident #118Resident #118 was admitted to the facility on [DATE], with a diagnosis of end stage renal disease.On 12/08/2025 at 9:10 AM, during a tour of the facility Resident #118's room lacked signage indicating the resident was on Enhanced Barrier Precautions (EBP).On 12/08/2025 at 12:59 PM, Resident #118 was lying in the resident's bed. The resident had an implanted dialysis catheter in the resident's right upper chest.On 12/10/2025 at 11:16 AM, a Licensed Practical Nurse (LPN) verbalized Resident #118 should be on EBP due to the resident having a dialysis catheter. The LPN confirmed Resident #118 did not have EBP in place, the resident's room lacked signage and clinical record lacked a physician order and an entry in the care plan regarding EBP. On 12/10/2025 at 11:36 AM, the IP verbalized EBP was used to help prevent the spread of Multi Drug-Resistant Organisms (MDROs) and would be implemented for residents who had implanted medical devices. The IP verbalized the IP was unsure if EBP had been implemented for Resident #118 as the IP had not reviewed the resident's record. On 12/10/2025 at 12:21 PM, the IP confirmed Resident #118 did not have EBP in place and should have been on EBP due to the presence of the dialysis catheter in the resident's upper chest.The facility policy titled Infection Prevention and Control Program (IPCP) Standard and Transmission-Based Precautions, reviewed 10/2022, documented EBP referred to the use of gowns and gloves during high-contact resident care activities and was to be used for residents with indwelling medical devices. EBP was intended to be in place for the duration of a resident's stay in the facility or until the discontinuation of the indwelling medical device.Investigation of infection trends in the facilityThe facility document titled Infection Prevention and Control Meeting Minutes, for review of October 2025, documented infection trends in the facility included increased Urinary Tract Infections (UTIs) and fungal infections.The facility document titled Infection Prevention and Control Meeting Minutes, for review of November 2025, documented infection trends in the facility included UTIs and fungal infections.On 12/11/2025 at 12:04 PM, the IP verbalized the purpose of the IP role in the facility was to facilitate the Infection Prevention and Control Program (IPCP) and provide education to staff on the facility's infection control policies. Infections within the facility were tracked using a monthly infection control tracking log and the facility's current most frequent infections were UTIs and skin infections. Interventions implemented related to the increase<br>(continued on next page) |

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| F 0882<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | in UTIs and skin infections included offering residents oral fluids and conducting shower audits.On 12/11/2025 at 12:35 PM, the IP verbalized shower audits occurred in November to investigate the increase in skin infections. While completing the audits, the IP found residents often refused showers. Certified Nursing Assistants (CNAs) were instructed to notify the resident's nurse when a resident refused a shower, the nurse would then ask the resident the reason for the refusal and offer a different type of bath. The IP explained the education was provided to staff verbally and the IP denied having documentation of the shower audits, education provided to staff, which staff were educated, when the education was provided, and any follow-up or outcomes afterward.The IP recalled investigation of the increase in UTIs consisted of the IP completing four observations of staff providing incontinence care to residents and the IP provided verbal education to one CNA. The IP denied any additional investigation occurred to determine factors which could have been contributing to the increase in UTIs in the facility and denied the intervention of offering fluids to residents was selected based on the outcome of an investigation. The IP denied having any documentation of observations of staff providing incontinence care, education provided to staff, which staff were educated, when the education was provided and any follow-up or outcomes afterward.A facility document Job Description - Infection Preventionist, signed by the IP on 09/22/2025, documented the primary purpose of the job position was to plan, organize, develop, and direct the infection control program and its activities in accordance with federal, state and local standards, and regulations. Essential duties and responsibilities included ensuring the facility was in compliance with Centers for Disease Control and Prevention (CDC) concerning infection control. To perform the job successfully, the IP must be able to perform each essential duty satisfactorily.The facility policy titled Infection Prevention and Control Program, reviewed 04/2025, documented elements of the IPCP were to be carried out by the IP and consisted of coordination/oversight, surveillance, data analysis, and prevention of infection. Under the infection control program the facility would investigate, control and prevent infections in the facility, decide what measures/interventions should be applied in individual circumstances, and maintain a record of incidence of infection and corrective action taken.The CDC document titled The Core Elements of Antibiotic Stewardship for Nursing Homes, 2015, documented the CDC recommended all nursing homes takes steps to improve antibiotic prescribing practices and reduce inappropriate use as harm from antibiotic overuse was significant for the frail and older adults receiving care in nursing homes. Seven core elements were necessary for implementing a successful ASP and included providing educational resources to clinicians, nursing staff, residents and families about antibiotic resistance and opportunities for improving antibiotic use. Nursing homes engaged residents and their family members in antibiotic use and stewardship educational efforts to ensure clinicians had their support to make appropriate antibiotic use decisions. Cross reference tags F880 and F881. |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, interview, and document review, the facility failed to ensure call light devices were kept within reach for 2 of 18 sampled residents (Resident #6 and #12). As a result, the residents were unable to request help with basic needs such as assistance with repositioning, discomfort, and thirst. This deficient practice had the potential to result in emotional distress related to the residents' loss of autonomy and had the potential to result in physical harm including dehydration, skin breakdown, pain, and discomfort. Findings include:Resident #6 Resident #6 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unilateral primary osteoarthritis, right hip, Alzheimer's disease, unspecified, pressure ulcer of sacral region, stage III, personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits. On 12/08/2025 at 12:59 PM, Resident #6 was sitting in a wheelchair placed on the right side of the resident's bed. Resident #6 wanted to lie down but could not reach the call light button to request help. The resident's call light button was a large round disc used by residents who had difficulty successfully pressing the button on a standard call light. Resident #6's call light button was sitting on the far-left side of the resident's bed and out of reach for the resident. A visitor turned the call light on for Resident #6 and went into the hallway to look for help. The Director of Nursing (DON) entered the room and located the resident's call light button on the opposite side of the bed from the resident. The DON confirmed the call light button should have been on the same side of the bed and within reach of the resident. On 12/11/2025 at 3:32 PM, the DON confirmed Resident #6's call light should have been on the same side of bed as the resident and explained Resident #6 had limited mobility and would not be able to reach the call light when it was across the bed from the resident. Resident #12 Resident #12 was admitted to the facility on [DATE], with diagnoses including Multiple Sclerosis, unspecified, neuromuscular dysfunction of the bladder, unspecified, major depressive disorder, recurrent, unspecified, pressure ulcer of unspecified part of back, stage III, contracture, unspecified joint, pain in joints of right and left hands. A Minimum Data Set 3.0 (MDS) assessment; Section GG, dated 09/12/2025 documented Resident #12 had unilateral upper extremity functional limitation in range of motion (shoulder, elbow, wrist, and hand). The resident was dependent, meaning the helper did all of the effort, and the resident did none of the effort to complete the activity, or the assistance of two or more helpers was required for the resident to complete the task. The effected care areas were eating, oral hygiene, toileting hygiene, showering/bathing, dressing including footwear, and personal hygiene. Personal hygiene included combing hair, shaving, applying makeup, and washing/drying face and hands. Resident #12 was dependent upon assistance to roll on to the resident's left and right sides. Task such as sitting up and lying back down, standing, transfers to and from chair/bed, toileting, showering, and walking were not attempted due to either the resident was not able to perform the task, there were environmental limitations, medical conditions, or safety concerns. The resident was not able to use a scooter or a wheelchair. On 12/08/2025 at 1:28 PM, Resident #12 was resting in bed. The resident's call light button, a round flat device was sitting on the resident's chest, below the chin. The resident explained the resident did not have use of the resident's arms and hands and used the chin to turn on the call light. Resident #12 verbalized the call light button often slid out of reach and staff would forget to place the call light button within reach before leaving the room. Resident #12 explained the resident was quadriplegic and depended on staff for help with everything, including eating, bathing and dressing. Resident #12 explained when the call light was not appropriately placed the resident was not able to call for assistance. The resident verbalized being unable to call for help made the resident feel frustrated, afraid and unsure someone was there to help. Resident #12 confirmed the resident did not have any functional use of the resident's upper extremities and depended upon staff for assistance with all activities of daily living including eating, bathing, dressing, and repositioning. On 12/10/2025 at 11:35 AM, Resident #12 was<br>(continued on next page) |

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| | 295020 | A. Building<br>B. Wing | 12/11/2025 |

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

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | resting in bed. The resident's call light button was lying on top of the resident, near the resident's waist. The resident was not able to reach the call light button. On 12/10/2025 at 3:05 PM, Resident #12 was resting in bed. The resident's call light button was lying in the same position on top of the resident, near the resident's waist. The resident was not able to reach the call light button. The resident verbalized the resident was cold and would like to be covered with the resident's quilt. The resident was not able to reach the call light button to call for help. On 12/11/2025 at 12:42 PM, Resident #12 was resting in bed and the resident's call light button was lying on top of the resident in the resident's right lower quadrant (lower abdomen). Resident #12 explained the resident had slipped down in bed causing the call light to slip down as well. The resident was not able to reach the call light. The resident's lunch tray was sitting on the resident's bed side table. Resident #12 asked for help to take a drink of coffee and confirmed the resident was not able to drink the coffee without help and could not call for help due to the resident being not able to reach the call light button. On 12/11/2025 at 1:27 PM, Resident #12 was resting in bed. The resident's call light button was lying on top of the resident's right hip. The resident was not able to reach the call light button. On 12/11/2025 at 3:28 PM, the Interim DON (IDON) verbalized the IDON's expectation was call lights would remain within a resident's reach at all times. All staff were expected to ensure call lights were within reach every time they left a resident's room. On 12/11/2025 at 3:33 PM, the IDON confirmed Resident #12's call light should be placed on the resident's chest, directly below the resident's chin and confirmed the resident operated the call light button with the resident's chin. IDON verbalized interventions such as clipping the call light to the resident's gown or blanket may be helpful. The IDON was not sure if the resident had been assessed by an Occupational Therapist regarding the use of the call light button and solutions to ensure the call light button stayed in place. The facility was not able to provide a policy related to the use and availability of call lights. Cross reference with F656 |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review, the facility failed to ensure a resident receiving an anticoagulant (blood thinning medication) with a history of epileptic seizures was assessed per facility policy after the resident reported vision changes and pain following a witnessed head injury for 1 of 10 resident's sampled for facility reported incident and complaint investigations. (Resident #28). This deficient practice had the potential for a resident to suffer an adverse outcome of intracranial bleeding or delayed seizure activity due to not receiving timely treatment because of the facility's failure to perform neurological checks or assess vital signs.Resident #28 was admitted to the facility on [DATE], with diagnoses including epilepsy, unspecified, not intractable, without status epilepticus and unspecified atrial fibrillation.A Nursing Progress Note, dated 12/01/2025, documented at approximately 2:00 PM the resident required four staff members to move the resident up in bed. The resident was scooted up in bed and the resident's head hit the headboard. The resident exclaimed in pain and complained of double vision. The Physician was notified and instructed nursing to monitor for any neurological changes.The clinical record for the resident did not include documented neurological checks or documentation of vital signs taken in the immediate three hours after the resident had hit their head and complained of visual changes.An Order Summary Report documented an order for Eliquis (a blood thinning medication) oral tablet, give 5 milligrams (mg) by mouth two times a day for atrial fibrillation. The order's start date was 11/26/2025.On 12/08/2025 at 10:41 AM, the Director of Nursing (DON) verbalized a neurological response assessment was included in the daily note completed on 12/01/2025 at 8:45 PM, approximately six hours after the resident had hit their head and complained of vision changes. The DON confirmed the first set of vital signs recorded after the resident had hit their head, was at 6:55 PM, approximately four hours later. The DON verbalized neurological checks, including vital signs, should have been completed and documented in the resident's record to ensure continued monitoring of the resident was completed.The medication guide for Eliquis, accessed at eliquis.bmscustomerconnect.com on 12/11/2025, documented Eliquis could cause serious side effects including bleeding and could lead to death. While taking Eliquis it could take longer than usual for bleeding to stop.The facility's standard of practice titled Lippincott Manual of Nursing Practice, Eleventh Edition, copyright 2018, documented the subsequent assessment after a resident experienced an injury to the head, spine, or face would include assessments for changes in level of consciousness and assessment of vital signs. Additional areas of assessment included assessing for impaired vision or seizure activity.FRI 2684353 |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, document review, and interview, the facility failed to develop a baseline care plan to address care and interventions for dialysis treatments for 1 of 18 sampled residents (Resident #116). This deficient practice had the potential to deprive a resident of necessary care and services related to dialysis and placed the resident at risk for not receiving appropriate treatment.Findings include:Resident #116Resident #116 was admitted to the facility on [DATE], with diagnoses including sepsis due to methicillin susceptible staphylococcus aureus, liver transplant status, altered mental status, unspecified, and end stage renal disease.A physician's order dated 12/06/2025, documented Resident #116 was to receive dialysis treatment at a dialysis center every Monday, Wednesday, and Friday. Special instructions: Vital signs before and after each session. Send/receive communication form with patient. Medical records to scan upon return.Resident #116's baseline care plan lacked a care plan for the care, treatment, and interventions for dialysis treatment.On 12/10/2025 at 4:11 PM, the Director of Nursing (DON) explained baseline care plans were required to be completed within 48 hours after admission to the facility, to include any unique health care needs and services staff would need to know to care for the resident properly. The DON reviewed Resident #116's baseline care plan and confirmed dialysis was not on the resident's baseline care plan. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**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 1) a resident with a care plan addressing the resident's preferences for female caregivers to mitigate potential triggers for re-traumatization was implemented for 1 of 10 residents sampled for facility reported incident and complaint investigations (Resident #11). This deficient practice had the potential to result in a resident experiencing re-traumatization causing psychosocial harm, 2) 1 of 18 sampled residents (Resident #12) had a care plan related to the positioning and monitoring of a call light device for use by individuals with limited mobility. This deficient practice had the potential to result in a lack of monitoring related to the positioning of the call light, the resident not being able to request help for basic needs, and psychosocial and physical harm related to the resident not receiving the services required to meet the resident's basic needs including pain, discomfort, and thirst; and 3) 1 of 18 sampled residents (Resident #5) had a care plan addressing a resident's use of a trapeze for increased mobility while in bed and pressure relieving tactics to avoid skin breakdown. The deficient practice had the potential to result in a lack of monitoring and supervision of use and effectiveness of the device to determine the mobility needs of the resident while in bed.Findings include:<br><br>Resident #11<br><br>Resident #11 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including bipolar disorder, unspecified, major depressive disorder, recurrent, unspecified, and schizophrenia, unspecified.<br><br>A facility reported incident, dated 07/23/2025, documented the resident had reported receiving a bed bath the night before from a male Certified Nursing Assistant (CNA). The resident reported feeling as if the CNA had been invasive when cleaning around the resident's anus. The resident reported the resident had reminded the CNA the resident was only supposed to receive bed baths from a female CNA. A staff member reported the resident seemed less lively than usual following the incident.<br><br>A Trauma Informed Care: Social Services Assessment/Evaluation, dated 02/16/2022, documented the resident had a history of intimate partner violence. The identified triggering events documented the resident did not trust men and preferred females to shower her to mitigate triggers to prevent re-traumatization.<br><br>A care plan, initiated on 06/28/2023, documented the resident required staff participation with bathing and should have had female caregivers for bed baths.<br><br>On 12/10/2025 at 10:17 AM, the resident verbalized the resident could not discuss the incident as it was too upsetting for the resident to talk about. The resident verbalized the resident had requested no male caregivers prior to receiving a bed bath from a male caregiver.<br><br>On 12/10/2025 at 11:13 AM, the Director of Nursing (DON) verbalized the resident had a care plan in place prior to the incident reported on 07/23/2025, indicating the resident was to have female caregivers only for bed baths. The DON confirmed the resident had received a bed bath from a male CNA and should not have had a male CNA.<br><br>The facility policy titled Comprehensive Person-Centered Care Planning, revised 01/2022,<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | documented the interdisciplinary team would develop and implement a care plan for each resident and the care plan would be based upon needs identified in the comprehensive assessment.<br><br>Cross reference with tag F699<br><br>FRI # 2570164<br><br>Resident #12<br><br>Resident #12 was admitted to the facility on [DATE], with diagnoses including Multiple Sclerosis, unspecified, neuromuscular dysfunction of the bladder, unspecified, major depressive disorder, recurrent, unspecified, pressure ulcer of unspecified part of back, stage III, contracture, unspecified joint, pain in joints of right and left hands.<br><br>A Minimum Data Set 3.0 (MDS) assessment; Section GG, dated 09/12/2025 documented Resident #12 had unilateral upper extremity functional limitation in range of motion (shoulder, elbow, wrist, hand). The resident was dependent, meaning the helper did all of the effort, and the resident did none of the effort to complete the activity, or the assistance of two or more helpers was required for the resident to complete the task. The effected care areas were eating, oral hygiene, toileting hygiene, showering/bathing, dressing including footwear, and personal hygiene. Personal hygiene included combing hair, shaving, applying makeup, and washing/drying face and hands. Resident #12 was dependent upon assistance to roll left and right. Task such as sitting up and lying back down, standing, transfers to and from chair/bed, toileting, showering, and walking were not attempted due to either the resident was not able to perform the task, there were environmental limitations, medical conditions, or safety concerns. The resident was not able to use a scooter or a wheelchair.<br><br>Resident #12's Comprehensive Care Plan did not include a care plan for the use of a modified call light related to the resident's lack of mobility and placement and monitoring of the call light device, and interventions to ensure the call light remained in place and available for the resident to use when needed.<br><br>On 12/08/2025 at 1:28 PM, Resident #12 was resting in bed. The resident's call light button was a flat round device. The resident explained the resident did not have use of the resident's hands and arms and used the chin to turn on the call light. Resident #12 verbalized the call light button often slid out of reach and staff would forget to place the call light button within reach before leaving the room. Resident #12 explained the resident was quadriplegic and depended on staff for help with everything, including eating, bathing and dressing. Resident #12 verbalized not being able to use the call light button when help was needed made the resident feel frustrated, afraid, and unsure someone was there to help.<br><br>Resident #12 confirmed the resident did not have any functional use of the resident's upper extremities and depended upon staff for assistance with all activities of daily living including eating, bathing, dressing, and repositioning.<br><br>On 12/11/2025 at 3:33 PM, the Interim Director of Nursing (IDON) confirmed Resident #12's call light should be placed on the resident's chest below the resident's chin because the resident operated the call light button with the resident's chin. The IDON verbalized interventions such as clipping the call light to the resident's gown or blanket may be helpful. The IDON was not sure if the resident had ever been assessed by an Occupational Therapist regarding the use of the call light button and solutions to (continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | ensure the call light button stayed in place.<br><br>On 12/11/2025 at 3:37 PM, the IDON confirmed Resident #12's Comprehensive Care Plan should include a care plan for the use, monitoring, and placement the resident's call light button. The IDON verbalized the resident had the special call light button because the resident was not physically able to operate a standard call light button. The IDON verbalized care plans were developed based on the care residents required and care plans needed to be person centered. The IDON verbalized a person-centered care plan would include interventions to help ensure the resident's call light stayed in place.<br><br>Cross reference with F558<br><br>Resident #5<br><br>Resident #5 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including gastro-esophageal reflux disease without esophagitis, major depressive disorder, recurrent, unspecified, and pressure ulcer of sacral region, stage three.<br><br>On 12/08/2025 at 9:37 AM, Resident #5 was sleeping in bed. Above the bed was a trapeze.<br><br>A Physical Therapy Evaluation and Plan of Treatment dated 11/05/2025, documented Resident #5's objective was to roll side to side in bed using a trapeze.<br><br>Resident #5's comprehensive care plan lacked documented evidence addressing the use of the trapeze to include goals and interventions.<br><br>On 12/10/2025 at 10:44 AM, the Administrator explained physical therapy will work with residents toward a prior level of function by evaluating and assessing residents. Once therapy completed an assessment, a recommendation will be put forth for a resident to try for a deeper level of success toward independence. Assistive devices were recommended on occasion if a resident could demonstrate how to use an assistive device and the device was safe for use.<br><br>The Administrator verbalized Resident #5 used a trapeze to allow the resident to be more independent with mobility in bed and to relieve pressure from the resident's body. The Administrator explained when an assistive device was used by a resident, the assistive device needed to be care planned as a method of communication for staff for the resident needs and services. The Administrator confirmed Resident #5 lacked a comprehensive care plan for the use of a trapeze device related to the resident's mobility.<br><br>On 12/10/2025 at 10:44 AM, the Physical Therapy Manager explained Resident #5 was not currently receiving physical therapy services, however the resident was assessed and evaluated for mobility by the use of a trapeze while in bed. IDT had discussed the resident during the weekly meetings and agreed with the resident use of a trapeze for mobility and pressure relieving stress from the resident.<br><br>The facility policy titled Comprehensive Person-Centered Care Planning, last revised January 2022, documented IDT would develop a comprehensive person-centered care plan for each resident to include measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs identified from the comprehensive assessment. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**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 Licensed Practical Nurses (LPNs) who performed Peripherally Inserted Central Catheter (PICC) line dressing changes for 1 of 18 sampled residents (Resident #96), received training and were deemed competent to perform the dressing change. This deficient practice had the potential to result in insertion site and blood stream infections for residents due to inaccurate technique when performing a sterile procedure.Findings include:Resident #96Resident #96 was admitted to the facility on [DATE], with diagnoses including sepsis, unspecified organism and bacteremia.On 12/08/2025 at 11:22 AM, Resident #96 had a PICC line in the resident's left upper arm. The insertion site was covered with a transparent dressing. The dressing lacked a date the dressing was changed and initials indicating who placed the dressing. Resident #96 verbalized the resident was receiving antibiotics for an infection in the resident's bladder and facility staff changed the PICC line dressing however, the resident was unsure when the dressing was last changed.Resident #96's Care Plan documented the following:-Resident #96 was admitted to the facility on Intravenous (IV) antibiotic therapy. Interventions included observing the IV site for signs and symptoms of complications such as redness, swelling, pain, draining and leakage. The date initiated was 11/12/2025.-Resident #96 was on IV antibiotic medication Cefazolin 2 grams IV every eight hours for 36 days. Interventions included checking dressing at site daily. The date initiated was 11/12/2025.A Physician's Order dated 11/19/2025, documented central line, PICC line, midline care: change dressings, change injection caps to each lumen with each dressing change and As Needed (PRN) if wet, loose, or soiled every seven days for catheter maintenance. The start date was 11/20/2025.Resident #96's November 2025 IV Medication Administration Record (MAR) documented central line, PICC line, midline care: change dressings, change injection caps to each lumen with each dressing change and PRN every seven days for catheter maintenance. The IV MAR documented the PICC line care was administered by LPN1 on 11/27/2025.On 12/11/2025 at 9:05 AM, a Registered Nurse (RN) assigned to care for Resident #96 confirmed the resident had a PICC line. The RN entered Resident #96's room and observed the dressing covering the PICC line in the resident's left arm. The RN verbalized the dressing lacked a date indicating when the dressing was changed.On 12/11/2025 at 9:17 AM, the Interim Director of Nursing (IDON) verbalized PICC line dressings were to be changed once per week and if the dressing was dislodged or soiled. The IDON's expectation of staff when performing PICC line dressing changes was to follow the guidelines in the facility's best practice reference (Lippincott Manual of Nursing Practice) and the care was to be documented on the IV MAR and/or in a nurse progress note.On 12/11/2025 at 10:33 AM, the IDON verbalized the facility's wound care nurse was responsible to complete PICC line dressing changes for residents in the facility.On 12/11/2025 at 10:39 AM, LPN2 who was also the facility's wound care nurse confirmed LPN2 typically performed the PICC line dressing changes for all residents with PICC lines in the facility.On 12/11/2025 at 11:00 AM, LPN2 and the IDON entered Resident #96's room and LPN2 changed the dressing on the resident's PICC line.On 12/11/2025 at 3:32 PM, the Administrator verbalized facility staff should receive training and have documentation the staff were competent to perform PICC line dressing changes prior to performing the dressing change. The Administrator verbalized the facility was unable to find documented evidence LPN1 and LPN2 received training and were deemed competent by the facility to perform PICC line dressing changes.The facility's LPN job description, undated, documented essential duties and responsibilities included administering services within the applicable scope of nursing practice such as applying and changing dressings/bandages as appropriate and in accordance with applicable standards.Nevada Administrative Code (NAC) 632.242 - Additional duties in area of specialization, documented an LPN may collect data and perform a skill, intervention or other duty in addition to those taught in an educational program for practical nurses if it is within the scope of<br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | practice of an LPN. The LPN and his or her employer shall maintain evidence of: the original documentation and demonstration of the acquired knowledge, skill and ability and annual verification of the nurse's continued competency through recertification or records of evaluations documenting satisfactory repeated performances of the knowledge, skill and ability in the nurse's area of practice.Cross reference tags F684 and F726. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**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 Peripherally Inserted Central Catheter (PICC) line dressing changes were performed according to physician orders for 1 of 18 sampled residents (Resident #96). This deficient practice had the potential to result in insertion site and bloodstream infections for residents.Findings include:Resident #96Resident #96 was admitted to the facility on [DATE], with diagnoses including sepsis, unspecified organism and bacteremia.On 12/08/2025 at 11:22 AM, Resident #96 had a PICC line in the resident's left upper arm. The insertion site was covered with a transparent dressing. The dressing lacked a date the dressing was changed and initials indicating who had changed the dressing. Resident #96 verbalized the resident was receiving antibiotics for an infection in the resident's bladder and facility staff changed the PICC line dressing however, the resident was unsure when the dressing was last changed.Resident #96's Care Plan documented the following:-Resident #96 was admitted to the facility on Intravenous (IV) antibiotic therapy. Interventions included to observe the IV site for signs and symptoms of complications such as redness, swelling, pain, draining and leakage. The date initiated was 11/12/2025.-Resident #96 was on IV antibiotic medication Cefazolin 2 grams IV every eight hours for 36 days. Interventions included to check dressing at site daily. The date initiated was 11/12/2025.A Physician's Order dated 11/19/2025, documented central line, PICC line, midline care: change dressings, change injection caps to each lumen with each dressing change and As Needed (PRN) if wet, loose, or soiled every seven days for catheter maintenance. The start date was 11/20/2025.Resident #96's November 2025 IV Medication Administration Record (MAR) documented central line, PICC line, midline care: change dressings, change injection caps to each lumen with each dressing change and PRN every seven days for catheter maintenance. The MAR included scheduled administrations on 11/20/2025 and 11/27/2025. The documentation for the scheduled administration on 11/20/2025 was missing and the entry was left blank.Resident #96's December 2025 IV MAR documented central line, PICC line, midline care: change dressings, change injection caps to each lumen with each dressing change and PRN every seven days for catheter maintenance. The MAR included scheduled administrations on 12/04/2025 and 12/11/2025 however, both entries lacked documentation and were left blank.On 12/11/2025 at 9:05 AM, a Registered Nurse (RN) assigned to care for Resident #96 confirmed the resident had a PICC line. The RN entered Resident #96's room and observed the dressing covering the PICC line in the resident's left arm. The RN verbalized the dressing lacked a date indicating when the dressing was changed.On 12/11/2025 at 9:17 AM, the Interim Director of Nursing (IDON) verbalized PICC line dressings were to be changed once per week and if the dressing was dislodged or soiled. The IDON's expectation of staff when performing PICC line dressing changes was to follow the guidelines in the facility's best practice reference (Lippincott Manual of Nursing Practice) and the care was to be documented on the IV MAR and/or in a nurse progress note. The IDON verbalized the IDON did not know if the guidelines in the best practice reference included any information related to documentation of dressing changes and if staff were required to label the dressing with the date changed however, it would be considered standard/usual nursing practice to include the date on the dressing. After reviewing Resident #96's record, the IDON confirmed the resident had a PICC line and verbalized the record indicated the last time the PICC line dressing was changed was on 11/27/2025.On 12/11/2025 at 10:33 AM, the IDON verbalized the facility's wound care nurse was responsible to complete PICC line dressing changes for residents in the facility.On 12/11/2025 at 10:39 AM, a Licensed Practical Nurse (LPN) who was also the facility's wound care nurse confirmed the LPN typically performed the PICC line dressing changes for all residents with PICC lines in the facility however, the LPN denied having completed dressing changes for Resident #96 as the LPN thought the floor nurses were completing them.On 12/11/2025 at 11:27 AM, the IDON explained the nursing staff working the floor had previously been<br>(continued on next page) |

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| | 295020 | A. Building<br>B. Wing | 12/11/2025 |

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

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | responsible to complete PICC line dressing changes for Resident #96. Approximately two weeks prior, the IDON became aware of the dressing changes not being completed as frequently as ordered and the IDON made the LPN/wound care nurse responsible for the dressing changes.Lippincott Manual of Nursing Practice 11th edition, copyright 2019, documented to ensure proper vascular access site assessment and care. Change the IV dressing on a routine basis and immediately if damp, loosened, or soiled. Transparent semipermeable dressings were to be changed every seven days.Cross reference tags F658 and F726. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and document review, the facility failed to 1) monitor a resident for significant weight loss and initiate timely interventions in accordance with facility policy and professional standards of practice for 1 of 18 sampled residents (Resident #16) and 2) ensure that 1 of 18 sampled residents (Resident #15) was weighed upon admission and weekly for four weeks, the Interdisciplinary Team (IDT) evaluated the resident following decreased oral intake to determine the cause and necessary interventions, and the physician was notified of the change in the resident's nutritional status. This deficient practice placed the residents at risk for compromised nutritional status and significant changes in weight without adequate oversight, monitoring, and intervention by facility staff.Findings include:<br><br>Resident #16<br><br>Resident #16 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including type 2 diabetes mellitus with other diabetic kidney complication, anxiety disorder, unspecified, and gastro-esophageal reflux disease without esophagitis.<br><br>Review of the Weights and Vitals Summary for Resident #16 revealed the resident weighed 139 pounds on 01/07/2025 and 113.1 pounds on 07/14/2025, reflecting a weight loss of 25.9 pounds or 18.63 percent (%). There was no documentation of weights obtained between January 2025 and July 2025 to verify or monitor the significant weight loss.<br><br>Review of the clinical record revealed Quarterly Nutrition Evaluations completed on 03/08/2025, 04/07/2025, and 07/08/2025, each documenting a recent weight of 139.0 pounds, which was inconsistent with the Weights and Vitals Summary. Review of monthly documentation from January 2025 through July 2025 indicated the resident refused weighing. There was no documentation to support alternative monitoring measures, including intake monitoring or body measurements, were completed during this time.<br><br>On 12/10/2025 at 2:07 PM, the Registered Dietitian (RD) verbalized weights were obtained from the electronic health record reports and nursing staff. The RD explained if a resident refused weights, the RD would observe the resident's meal intake during rounds. The RD confirmed the weight loss for Resident #16 would have been noticeable and stated there was no documentation from the prior RD indicating awareness of the weight loss prior to the recorded weight on 07/14/2025. The RD further confirmed no nutritional interventions had been initiated related to the significant weight loss.<br><br>On 12/11/2025 at 2:05 PM, the Interim Director of Nursing (IDON) confirmed Resident #16 experienced significant weight loss based on the weight obtained on 07/14/2025. The DON explained staff were expected to document weight refusals, reattempt weights, and utilize alternative methods such as intake monitoring and body measurements. The DON confirmed there was no documentation Resident #16 had been weighed using alternative methods, had body measurements completed, or had nutritional interventions initiated by the RD related to the significant weight loss.<br><br>The facility policy titled Nutrition Status Management, revised 04/2025, stated each resident's nutritional status and needs, including medications and medical conditions to ensure all residents maintain acceptable parameters of nutritional status, such as body weight and other available data, unless the resident's clinical condition demonstrates not possible.<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #15<br><br>Resident #15 was admitted to the facility on [DATE], with diagnoses including hemiplegia and hemiparesis following other cerebrovascular disease affecting right dominant side and unspecified dementia, unspecified severity, with agitation.<br><br>On 12/08/2025 at 1:26 PM, Resident #15 was lying in the resident's bed. The resident lifted the resident's head slightly off the pillow in response to surveyors knocking on the door however, the resident did not respond to any questions from surveyors. The resident appeared thin.<br><br>Resident #15's clinical record documented the following weights:<br><br>-10/23/2025, 165 pounds (lbs.)<br><br>-11/10/2025, 135.7 lbs.<br><br>Resident #15's Care Plan documented the resident had a nutritional problem or potential nutritional problem related to dysphagia, puree diet with slightly thickened liquids, edentulism, and dementia. Interventions included:<br><br>-Monitor and report to physician as needed for any sign/symptoms of decreased appetite, nausea/vomiting, unexpected weight loss, and complaints of stomach pain. The date initiated was 10/17/2025.<br><br>-Monitor/record/report to physician signs/symptoms of malnutrition: emaciation (cachexia), muscle wasting, and significant weight loss. The date initiated was 10/23/2025.<br><br>A Mini Nutritional assessment dated [DATE], documented Resident #15 was at risk for malnutrition.<br><br>An RD – Nutrition Risk Review dated 10/23/2025, documented Resident #15's admission weight was 165 lbs. The resident was at nutritional risk related to dysphagia, mechanically altered det, thickened liquids, and dementia. Oral intake was 50-75% of meals. Will monitor weights and make changes as needed.<br><br>A Weight Change Note dated 11/26/2025, documented weight warning, 17.8% change. Reweight pending.<br><br>On 12/09/2025 at 2:45 PM, Resident #15 was sitting in the resident's bed. The resident's significant other was sitting in a chair near the bed and explained the significant other visited multiple times per week. The significant other verbalized the significant other thought Resident #15 had lost weight since being admitted to the facility and had been informed by facility staff the resident ate approximately one meal per day.<br><br>On 12/10/2025 at 12:50 PM, a Certified Nursing Assistant (CNA) verbalized the CNA thought residents were weighed once a week while in the facility and explained staff would be informed by one of the facility's Assistant Directors of Nursing (ADON) when a resident needed to be weighed. The CNA verbalized Resident #15 required staff assistance to eat and over the previous two weeks the resident had not wanted to eat much, often less than 25% of each meal. The CNA verbalized the CNA did not know if Resident #15 had lost weight since being admitted to the facility.<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/10/2025 at 2:06 PM, the RD verbalized an assessment of a resident's nutritional needs was completed upon admission and quarterly or more frequently if needed. Residents were to be weighed upon admission, weekly for three weeks, then monthly afterward if the weight was stable.<br><br>If a resident lost weight the facility would implement weekly weights and if the weight loss was significant, the RD would observe the resident during a meal, try to determine the cause of the weight loss and the resident would be discussed during the facility's weekly nutrition meeting. The nutrition meetings were attended by the RD, the ADON, the Wound Nurse, and the DON and were documented in a Nutrition IDT note.<br><br>The RD verbalized the RD became aware of Resident #15's weight loss on 12/10/2025. The RD explained the RD had not considered Resident #15 to have weight loss as the resident was not weighed upon admission. The admission weight in the resident's record was a stated weight from the resident's family member, and the RD was not sure if the facility had completed a re-weight of the resident after 11/10/2025. A supplement was added 12/10/2025 due to the RD identifying Resident #15 had not been eating well.<br><br>The RD verbalized the RD did not have documentation of Resident #15 being discussed during the weekly nutrition meetings, denied direct care staff had informed the RD of the resident's decreased meal intake and denied having evaluated the resident for potential causes of weight loss.<br><br>On 12/11/2025 at 2:05 PM, the IDON verbalized residents were to be weighed upon admission, weekly for four weeks and monthly afterward if weights were stable. Weighing residents upon admission and weekly for four weeks enabled staff to get a baseline for the residents and monitor for weight loss or gain. If a resident refused to be weighed, the IDON's expectation of staff was to document the refusal in the electronic medical record. The facility's RD was to evaluate all residents upon admission for nutritional risk, review residents' preferences, and provide recommendations to the IDT as needed. Other ways staff could monitor residents' nutritional status aside from weights included amount of food the resident was eating, arm circumference, and girth measurement. Changes in nutritional status were to be reported to the physician.<br><br>The IDON verbalized Resident #15 was assessed for nutritional risk on 10/23/2025 and determined to be at risk related to dysphagia and dementia. Staff were to monitor weights and make changes as needed. The IDON denied Resident #15 was weighed upon admission and weekly for four weeks and verbalized the IDON was not sure why the weights weren't completed. The IDON confirmed Resident #15 had a documented decrease in meal intake and verbalized the IDON could not find documented evidence the physician was notified of the change. The IDON denied Resident #15 had been discussed at the facility's weekly nutritional meetings and denied interventions to address changes in the resident's nutritional status had been implemented by the facility prior to 12/11/2025.<br><br>The facility policy titled Nutrition Status Management, reviewed 04/2025, documented each resident's nutritional status was to be assessed upon admission and quarterly thereafter. Each resident was to be weighed upon admission, weekly for four weeks, and monthly thereafter. If there was a significant change in the resident's condition related to weight or nutrition, the RD would make recommendations to offer additional nutrition to those residents. The IDT and/or RD would monitor and evaluate the resident's response to the interventions. Nutritional assessment included but was not limited to weighing and weight changes and oral intake of foods and fluid. Any resident weight varying from the previous reporting period by more than 5% in 30 days or 7.5% in 90 days would be weighed weekly and evaluated by the IDT to determine the cause and interventions required. Weekly weights would be<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | reviewed by the RD or designee and the nurse would notify the physician, family and/or resident of weight loss/gain and interventions. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure enteral nutrition was labeled according to professional standards and facility policy for 1 of 18 sampled residents (Resident #12). This deficient practice had the potential to compromise patient safety by increasing the risk of contamination and infections, and improper hydration management, potentially leading to adverse health outcomes.Findings include:Resident #12Resident #12 was admitted on [DATE] with diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, cerebral aneurysm, and required assistance with personal care.On 12/10/2025 at 4:24 PM, during an observation of enteral feeding administration, the tube feeding pouch (secondary container to hold formula) was hanging in Resident #12's room without required labeling. The tube feeding pouch was not labeled with the resident's name, formula name, date and time hung, or expiration/beyond-use time.A physician order, dated 11/14/2025, documented Jevity 1.5 calorie formula via gastrostomy tube via pump two times per day at 65 cubic centimeters (cc) per hour for 20 hours, for a total of 1,949 kilocalories. The order directed staff to start the pump at 12:00 PM and turn the pump off at 8:00 AM. The order also directed free water administration at 30 milliliters (ml) per hour for 20 hours via pump.A physician order, dated 09/14/2025, documented tube care was to be provided every day shift.On 12/10/2025 at 4:26 PM, a Licensed Practical Nurse (LPN) verbalized when tube feeding pouches were hung, they should have been dated and labeled, and without labeling, staff would have been unable to determine when the feeding was hung. The LPN confirmed the feeding pouch for Resident #12 was missing all labeling.On 12/10/2025 at 4:28 PM, the Interim Director of Nursing (DON) explained new tubing should have been used, and bottles should have been labeled, and expressed infection control concerns if the formula was older than 24 hours. The DON further explained the nurses were responsible for labeling enteral feeding containers.The facility policy titled Tube Feeding Policy/Procedure, revised 02/2024, documented the feeding bag was to be labeled with the resident's name, room number, date and time started, kind and strength of feeding, volume, delivery rate, and initials of the staff member initiating the feeding. The feeding container was to be labeled with the time started with each new feeding, and the feeding container, tubing, and syringe were to be changed every 24 hours. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**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 the oxygen was administered and saturation levels were monitored according to a physician order for 1 of 18 sampled residents (Resident #8). This deficient practice had the potential to cause exacerbation of the resident's underlying health conditions.Findings include:Resident #8Resident #8 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including chronic diastolic (congestive) heart failure, cognitive communication deficit, and atherosclerotic heart disease of native coronary artery without angina pectoris.On 12/08/2025 at 9:45 AM, Resident #8 was observed seated in a wheelchair next to the resident's bed. An oxygen concentrator was located on the opposite side of the bed and was running. The tubing from the oxygen concentrator was traced across the bed but was not connected to the resident via nasal cannula, and oxygen was not being administered. A physician's order dated 08/22/2025, documented Oxygen at two liters per minute (lpm) via nasal cannula continuously.A physician's order dated 08/22/2025, documented may titrate Oxygen to keep sats greater than 90 % as needed.The Care Plan for Oxygen dated 08/22/2025, documented the resident had Oxygen Therapy related to ineffective gas exchange. Interventions were as follows:-administer as ordered by the physician. Monitor and document side effects and effectiveness.-Monitor for signs and symptoms of respiratory distress and report to the doctor as needed.-Oxygen settings via nasal canula at two lpm continuously.On 12/09/2025 at 8:13 AM, Resident #8 was seated in the resident's wheelchair next to the bed. The resident was not wearing a nasal canula indicating administration of Oxygen to the resident; however, the Oxygen concentrator was running at 2 lpm, with the Oxygen tubing lying on the resident's bed in a bundle.On 12/09/2025 at 8:30 AM, a Licensed Practical Nurse (LPN) explained the resident had a physician order for continuous oxygen at 2 lpm, issued a few months back and the resident's Oxygen saturation levels were to be checked every shift and documented in the resident's clinical record. The LPN verbalized the resident was supposed to be on Oxygen at all times and titrated up and down depending on the saturation levels taken every shift. The LPN verbalized the resident would often times take off the Oxygen from the resident's face and place the tubing on the bed. Staff were to round on the resident every two hours, and more frequently if needed, to ensure the resident was wearing the Oxygen. If the resident did not have the Oxygen on and administration of the Oxygen was not occurring, staff were to enter the room and put the Oxygen back on the resident.On 12/09/2025 at 8:37 AM, the LPN was unable to locate documentation of the saturation levels in the resident's clinical record. The LPN confirmed the resident was not being administered Oxygen per the physician's order and verbalized the resident could experience confusion and get lethargic if the resident's saturation levels were low causing a safety risk to the resident.On 12/09/2025 at 2:40 PM, the Director of Nursing (DON) explained the facility did not have a policy on taking resident Oxygen saturation levels; however, the expectation was if a resident had an order to titrate Oxygen, the resident's saturation levels would be monitored and documented by staff every shift. Once saturation levels were taken, the resident's Oxygen would be titrated according to the physician's order. In addition, if a resident had a physician's order to administer Oxygen continuously, then the resident should be on Oxygen at all times. If a resident was not on Oxygen at all times, the resident could experience Oxygen desaturation levels considered a health risk.The Weights and Vitals Summary-Oxygen Sats Summary lacked documented evidence Oxygen saturation levels were taken for Resident #8 on 12/06/2025 and 12/08/2025.On 12/10/2025 at 8:34 AM, Resident #8 was seated in the resident's wheelchair next to the bed. The Oxygen concentrator was on, and the Oxygen tubing was bundled on top of the Oxygen concentrator, not affixed to the resident.On 12/10/2025 at 8:37 AM, the LPN entered Resident #8's room and did not acknowledge the resident was not receiving oxygen via nasal cannula. The LPN took the Oxygen tubing off of the top of the Oxygen concentrator and placed the tubing on Resident #8's bed. The LPN<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | walked out of the resident's room.On 12/10/2025 at 8:41 AM, the LPM walked past Resident #8's room, glanced into the room at the resident, and kept walking down the hallway.On 12/10/2025 at 8:42 AM, the LPN and the Administrator entered Resident #8's room and did not acknowledge the resident was not receiving oxygen via nasal cannula. The LPN and Administrator left Resident #8's room.On 12/10/2025 at 8:59 AM, Resident #8 did not have Oxygen being administered to the resident and the Oxygen tubing was on the resident's bed.On 12/10/2025 at 4:01 PM, the DON explained Oxygen was considered a medication and a physician's order for continuous Oxygen and physician's orders for titration were to be followed at all times. The DON confirmed Resident #8 did not have Oxygen saturation levels documented on 12/06/2025 and 12/08/2025. The DON confirmed the physician's orders for administration of Oxygen to Resident #8 on a continuous basis were not being followed.The facility policy titled Administration of Drugs, last revised July 2025, documented medications must be administered in accordance with the written physician's orders.The facility policy titled Oxygen Administration, last revised April l2016, documented Oxygen therapy was to be administered as ordered by the physician. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interview, and document review, the facility failed to maintain completed dialysis communication forms for 1 of 18 sampled residents (Resident #116). This deficient practice had the potential to result in a lack of critical information shared between the facility and the dialysis provider with the potential to have lead to delays and errors in care, adversely having affected resident health and safety.Findings include:Resident #116Resident #116 was admitted to the facility on [DATE], with diagnoses including sepsis due to methicillin susceptible staphylococcus aureus, liver transplant status, altered mental status, unspecified, and end stage renal disease.A physician's order dated 12/06/2025, documented Resident #116 was to receive dialysis treatment at a dialysis center every Monday, Wednesday, and Friday. Special instructions: Vital signs before and after each session. Send/receive communication form with patient. Medical records to scan upon return.Resident #116's clinical record lacked documented evidence of a completed dialysis communication transfer form for Monday, 12/08/2025.On 12/11/2025 at 12:39 PM, the Assistant Director of Nursing (ADON) explained December 8, 2025, was the resident's first dialysis appointment since admission to the facility and the resident was sent with a dialysis communication form. The form was necessary for a resident to take to dialysis because staff were to document pre-dialysis vital signs. The form also included critical notes the facility needed while the resident was at dialysis and post-dialysis vital signs were to be documented on the form. All documentation contained on the dialysis communication sheet was essential for facility staff to review in order to properly monitor the resident for any health concerns that were not part of the resident's baseline. If any concerns were noted, the resident's physician would need to be contacted. The ADON confirmed the dialysis communication form could not be located for Resident #116's dialysis appointment on 12/08/2025.On 12/11/2025 at 12:47 PM, the Director of Nursing (DON) verbalized dialysis communication forms were required to obtain and retain at the facility. The dialysis communication form informed the facility staff what the resident's vitals were prior to dialysis, if dialysis had any concerns related to the resident during the dialysis appointment, and the resident's vitals upon return to the facility. All information was important to review and retain to ensure there was not any health concerns with the resident. The DON confirmed the facility did not have a dialysis communication sheet for Resident #8 for the dialysis appointment on 12/08/2025.The facility policy titled Dialysis (Renal), Pre-and Post-Care, last revised May 2023, documented the facility was to assist residents in maintaining homeostasis pre and post renal dialysis, assess and maintain patency of renal dialysis access, assess resident daily for function related to renal dialysis, and participate in ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. The staff were to observe for any concerns about the resident's condition that may influence the dialysis treatment that needing addressing and observing for significant changes in medical condition upon returning from dialysis. The communications forms related to dialysis care would be placed in the residents' clinical record. |

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| | 295020 | A. Building<br>B. Wing | 12/11/2025 |

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| Rosewood Rehabilitation Center | 2045 Silverada Blvd<br>Reno, NV 89512 |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care or services that was trauma informed and/or culturally competent.<br><br>**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 with a documented history of trauma received trauma informed care based on the triggering factors identified in the trauma assessment for 1 of 10 residents sampled for facility reported incident and complaint investigations (Resident #11). This deficient practice had the potential to result in a resident experiencing re-traumatization and experiencing an intense reaction causing psychosocial harm.Findings include:Resident #11Resident #11 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including bipolar disorder, unspecified, major depressive disorder, recurrent, unspecified, and schizophrenia, unspecified. A facility reported incident, dated 07/23/2025, documented the resident had reported receiving a bed bath the night before from a male Certified Nursing Assistant (CNA). The resident reported feeling as if the CNA had been invasive when cleaning around the resident's anus. The resident reported the resident had reminded the CNA the resident was only supposed to receive bed baths from a female CNA. A staff member reported the resident seemed less lively than usual following the incident.A Trauma Informed Care: Social Services Assessment/Evaluation, dated 02/16/2022, documented the resident had a history of intimate partner violence. The identified triggering events documented the resident did not trust men and preferred females to shower her to mitigate triggers to prevent re-traumatization.A care plan, initiated on 06/28/2023, documented the resident required staff participation with bathing and should have had female caregivers for bed baths.A Social Services Progress Note, dated 07/27/2025, documented the resident had expressed difficulty sleeping due to the incident with the CNA on 07/23/2025.On 12/09/2025 at 2:51 PM, a Social Worker verbalized a resident would be assessed for trauma upon admission and the information would be communicated to the direct care staff via the assessment. The Social Worker verbalized the Trauma Informed Care assessment had indicated the resident should not have had male caregivers providing the resident with a bed bath. On 12/10/2025 at 10:17 AM, the resident verbalized the resident could not discuss the incident as it was too upsetting for the resident to talk about. The resident verbalized the resident had requested no male caregivers prior to receiving a bed bath from a male caregiver.On 12/10/2025 at 11:13 AM, the Director of Nursing (DON) verbalized the resident had a care plan in place prior to the incident reported on 07/23/2025, indicating the resident was to have female caregivers only for bed baths. The DON confirmed the resident had received a bed bath from a male CNA and should not have had a male CNA.The facility policy titled Behavioral Health Services, revised 04/2025, documented trauma survivors would receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences to eliminate or mitigate triggers with the potential to cause re-traumatization of the resident.Cross reference with tag F656FRI #2570164 |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>**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 staff received training and were deemed competent by the facility to provide care to Peripherally Inserted Central Catheters (PICCs) prior to being assigned to care for 1 of 18 sampled residents (Resident #96). This deficient practice had the potential to result in insertion site and blood stream infections for residents due to lack of knowledge of correct technique for dressing changes and signs and symptoms of potential complications.Findings include:Resident #96Resident #96 was admitted to the facility on [DATE], with diagnoses including sepsis, unspecified organism and bacteremia.On 12/08/2025 at 11:22 AM, Resident #96 had a PICC line in the resident's left upper arm. The insertion site was covered with a transparent dressing. The dressing lacked a date the dressing was changed and initials indicating who placed the dressing. Resident #96 verbalized the resident was receiving antibiotics for an infection in the resident's bladder and facility staff changed the PICC line dressing however, the resident was unsure when the dressing was last changed.Resident #96's Care Plan documented the following:-Resident #96 was admitted to the facility on Intravenous (IV) antibiotic therapy. Interventions included observing the IV site for signs and symptoms of complications such as redness, swelling, pain, draining and leakage. The date initiated was 11/12/2025.-Resident #96 was on IV antibiotic medication Cefazolin 2 grams IV every eight hours for 36 days. Interventions included checking the dressing at the insertion site daily. The date initiated was 11/12/2025.A Physician's Order dated 11/19/2025, documented central line, PICC line, midline care: change dressings, change injection caps to each lumen with each dressing change and As Needed (PRN) if wet, loose, or soiled every seven days for catheter maintenance. The start date was 11/20/2025.Resident #96's November 2025 IV Medication Administration Record (MAR) documented central line, PICC line, midline care: change dressings, change injection caps to each lumen with each dressing change and PRN every seven days for catheter maintenance. The MAR documented the central line care was administered by a Licensed Practical Nurse (LPN1) on 11/27/2025.The November 2025 IV MAR documented central line/midline flush orders: flush each lumen with 10 milliliters (ml) Normal Saline (NS) before and after IV medications and IV fluids. Check blood return and flush non-used ports with 10 ml NS every shift for catheter maintenance. Use only 10 ml syringes to flush all central line lumens.The MAR documented the central line flush orders were administered by the following staff members on the following dates:-LPN1 on 11/21/2025, 11/24-11/27/2025, and 11/29/2025.-LPN2 on 11/20/2025, 11/27/2025 and 11/28/2025.-LPN3 on 11/22/2025.On 12/11/2025 at 9:05 AM, a Registered Nurse (RN) confirmed the RN was assigned to care for Resident #96. The RN demonstrated a lack of competency in PICC line care when the RN verbalized PICC line dressings were to be changed daily.On 12/11/2025 at 9:17 AM, the Interim Director of Nursing (IDON) verbalized PICC line dressings were to be changed once per week and if the dressing was dislodged or soiled. The IDON's expectation of staff when performing PICC line dressing changes was to follow the guidelines in the facility's best practice reference (Lippincott Manual of Nursing Practice) and the care was to be documented on the IV MAR and/or in a nurse progress note.On 12/11/2025 at 10:33 AM, the IDON verbalized the facility's wound care nurse was responsible for completing PICC line dressing changes for residents in the facility.On 12/11/2025 at 10:39 AM, LPN4 who was also the facility's wound care nurse confirmed the LPN4 typically performed the PICC line dressing changes for all residents with PICC lines in the facility.On 12/11/2025 at 11:00 AM, LPN4 and the IDON entered Resident #96's room and the LPN4 changed the dressing on the resident's PICC line.On 12/11/2025 at 3:32 PM, the Administrator verbalized facility staff should receive training and have documentation the staff were competent to perform PICC line dressing changes prior to performing the dressing change. The Administrator verbalized the facility was unable to find documented evidence the LPN, LPN2, LPN3,<br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | LPN4 and the RN received training and were deemed competent by the facility to perform PICC line care. The Administrator provided a printed synopsis of an online training module which would usually be assigned to staff prior to caring for PICC lines.The facility document titled Care for PICC Lines, release date 03/01/2022, documented the training presented how to care for a PICC line. Topics covered in the course outline included: pre-procedure, flushing a PICC, locking a PICC, performing PICC dressing changes, and post-procedure.The facility's LPN job description documented essential duties and responsibilities included administering services within the applicable scope of nursing practice such as applying and changing dressings/bandages as appropriate and in accordance with appliable standards.Nevada Administrative Code (NAC) 632.242 - Additional duties in area of specialization, documented an LPN may collect data and perform a skill, intervention or other duty in addition to those taught in an educational program for practical nurses if it is within the scope of practice of an LPN. The LPN and his or her employer shall maintain evidence of: the original documentation and demonstration of the acquired knowledge, skill and ability and annual verification of the nurse's continued competency through recertification or records of evaluations documenting satisfactory repeated performances of the knowledge, skill and ability in the nurse's area of practice.Lippincott Manual of Nursing Practice 11th edition, copyright 2019, documented to ensure proper vascular access site assessment and care. Change the IV dressing on a routine basis and immediately if damp, loosened, or soiled. Transparent semipermeable dressings were to be changed every seven days.The CDC document titled Summary of Recommendations: Guidelines for the Prevention of Intravascular Catheter-Related Infections, dated 02/28/2024, documented the following:-Recommendations for catheter education, training, and staffing: Educate healthcare personnel regarding the indications for intravascular catheter use, proper procedures for the insertion and maintenance of intravascular catheters, and appropriate infection control measures to prevent intravascular catheter-related infections. Designate only trained personnel who demonstrate competence for the insertion and maintenance of peripheral and central intravascular catheters. Periodically assess knowledge of and adherence to guidelines for all personnel involved in the insertion and maintenance of intravascular catheters.-Recommendations for catheter site dressing regimens: Replace catheter site dressing if the dressing becomes damp, loosened or visibly soiled. Replace dressing used on short-term central venous catheters (CVCs) at least every seven days for transparent dressings. Replace dressings every two days for gauze dressings.Cross reference tags F658 and F684. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and document review, the facility failed to 1) ensure a medication ordered for the relief of shortness of breath and pain was available for a resident receiving hospice services for 1 of 10 residents sampled for facility reported incident and complaint investigations (Resident #86), This deficient practice had the potential to result in a resident not receiving timely relief from pain or shortness of breath and experiencing unnecessary and prolonged suffering at the end of life, and 2) maintain accurate controlled substance logs for four unsampled residents (Resident #81, # 1, #7, and #63) in 2 of 2 reviewed narcotic logs. This deficient practice had the potential to result in medication errors, inaccurate documentation of controlled substances, and increased risk of harm to residents due to improper handling of medications.Findings include:<br><br>Resident #86<br><br>Resident #86 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including dysphagia following cerebral infarction, cerebrovascular disease affecting left non-dominant side, and anxiety disorder, unspecified.<br><br>A care plan, initiated 05/06/2024, documented the resident had shortness of breath.<br><br>The Order Summary Report documented the following orders:<br><br>- - Admit to hospice for a terminal diagnosis. The order start date was 07/24/2025.<br><br>- - Morphine sulfate (concentrate) solution 20 milligrams (mg)/milliliter (ml), give 0.25 ml by mouth every four hours as needed for shortness of breath or pain. Hospice to provide. The order start date was 10/28/2025.<br><br>The Hospice Interdisciplinary Group Assessment and Plan of Care Update Report, dated 12/08/2025, documented an order for morphine concentrate 20 mg/ml, give 0.25 ml by mouth every four hours as needed for pain or shortness of breath.<br><br>On 12/09/2025 at 9:27 AM, the hospice Registered Nurse (RN) Case Manager (CM) verbalized the facility's floor nurse would inform the hospice RNCM if a medication refill was needed.<br><br>On 12/10/2025 at 9:56 AM, during a review of the resident's medications with the facility RN, the morphine was not available to review.<br><br>The facility RN verbalized the medication was not on site and should have been ordered and available in case the resident needed the medication for pain.<br><br>On 12/10/2025 at 11:06 AM, the Director of Nursing (DON) verbalized the medication should have been ordered and available on site.<br><br>The facility policy titled Controlled Medications – Storage and Reconciliation, revised 01/2022, documented medications would be reconciled to ensure an accurate inventory of medications by accounting for controlled medications.<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | FRI #2584530<br><br>Controlled substance logs (Station B)<br><br>On 12/11/2025 at 2:17 PM, the following discrepancies were found during a reconciliation of the Controlled Substance log for Station B back hall.<br><br>Resident # 81<br><br>Resident #81 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of personal history of (healed) traumatic fracture.<br><br>A physician's order dated 11/27/2025 documented pregabalin oral capsule, 75 mg, give one capsule by mouth one time a day for chronic pain for 30 days.<br><br>A Controlled Drug Record (CDR) documented Resident #81 had 21 capsules of pregabalin remaining. A medication card/container containing pregabalin could not be located for Resident #81 in the medication cart.<br><br>Resident #1<br><br>Resident #1 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of polyneuropathy, unspecified.<br><br>A physician's order dated 11/26/2025, documented pregabalin 75 mg capsules, give one capsule by mouth one time per day for pain for 30 days.<br><br>A physician's order dated 12/04/2025, documented oxycodone HCL (hydrochloride) 10 mg oral tablet, give one tablet by mouth two times per day for pain for 30 days.<br><br>A CDR documented Resident #1 had six capsules of pregabalin remaining. A medication card/container containing pregabalin could not be located for Resident #1 in the medication cart.<br><br>A CDR documented Resident #1 had 10 tablets of oxycodone remaining. A medication card/container containing oxycodone could not be located for Resident #1 in the medication cart.<br><br>Resident #7<br><br>Resident #7 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including bipolar disorder, and anxiety disorder.<br><br>A physician's order dated 12/08/2025, documented diazepam 5 mg tablets, give one tablet by mouth two times per day for 30 days, for anxiety.<br><br>A CDR documented Resident #7 had one tablet of diazepam remaining, the last dose documented as given was administered on 12/10/2025 at 9:50 PM. The resident's medication card for diazepam was empty.<br><br>On 12/11/2025 at 2:17 PM, the ADON looked for the medications in the drawer designated for<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | controlled substances and in the drawers containing uncontrolled medications. The ADON confirmed a card containing pregabalin could not be located in the medication cart for Resident #31, and a card containing pregabalin and a card containing oxycodone could not be located in the medication cart for Resident #1.The ADON expressed when controlled substances were missing from a medication cart the concern was the medications were being diverted or mixed in with other medication which could cause a medication error.<br><br>The ADON confirmed Resident #7's CDR documented one dose should be remaining and the medication card was empty. The ADON explained the nurse had administered the medication, but did not sign the medication out on the CDR.<br><br>Controlled substance log (Station A)<br><br>Resident #63<br><br>Resident #63 was admitted to the facility on [DATE], with a diagnosis of unspecified osteoarthritis, unspecified site.<br><br>A physician's order dated 12/01/2025, documented an order for hydrocodone-acetaminophen 5-325 mg (hydrocodone), give one tablet by mouth every four hours as needed for increased pain, for 14 days.<br><br>On 12/11/2025 at 2:35 PM, Resident #63's CDR documented there were 36 tablets of hydrocodone remaining, and the resident's medication card contained 37 tablets of hydrocodone. The ADON verbalized the concern was the resident requested but did not receive the medication.<br><br>The facility policy titled Controlled Medications – Storage and Reconciliation revised 04/2025, documented the facility maintained a process for the monitoring, administration, documentation, and reconciliation of controlled substances. When a controlled substance was administered, the licensed nurse administering the medication immediately entered the date and time of administration and the amount administered. After the medication was administered the record was signed by the administering nurse. A physical inventory and reconciliation of all controlled medications was completed by two nurses and documented at the change of each shift. |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>Based on interview and document review, the facility failed to ensure the menu was followed for a breakfast service. This deficient practice had the potential to affect all residents in the facility by not honoring diets, preferences, and not notifying residents of a menu change.Findings include:On 12/10/2025 at 9:07 AM, during a resident council meeting, 8 of 8 residents verbalized the facility would often serve the residents food not on the menu. The staff would not provide any notification to the residents and serve whatever the facility felt like serving.Resident #44 verbalized for breakfast on 12/10/2025, the residents were supposed to receive waffles for breakfast. Some residents received waffles and some received French toast. Resident #44 explained no notification was given to the residents of the change and the resident was looking forward to waffles, but was instead served French toast with no explanation from the staff. The resident verbalized this concern had previously been brought to the staff's attention.The Resident Council Meeting Minutes from 09/26/2025, documented the residents would love to be notified of meal changes with the food being served.The Good For Your Health Menus, dated December 8, 2025 through December 14, 2025, documented on 12/10/2025 for breakfast, the residents would be served waffles, warm syrup, breakfast meat, hot or cold cereal, and milk/juice.On 12/10/2025 at 11:47 AM, the [NAME] verbalized for breakfast on 12/10/2025, the residents were served waffles and sausage. The [NAME] explained there were plenty of waffles for all residents, the facility did not run out of waffles, however, some residents were served French toast. The [NAME] verbalized no alternative food requests were made for breakfast service and could not explain why some residents were served French toast for breakfast. The [NAME] explained if the food menu changed in any way, the staff did not notify residents of the change of food, the staff would just serve the food to the residents.On 12/10/2025 at 11:47 AM, the Kitchen Manager (KM) verbalized when residents requested an alternative meal, the tickets were kept in the kitchen. The KM could not locate any alternative requests for breakfast service on 12/10/2025. The KM explained the residents were supposed to be served waffles and sausage for breakfast, however, some French toast was served to residents during breakfast service with no notification provided to the resident. The KM could not clarify why French toast was served to residents and confirmed the facility was not following the menu, did not notify residents of the meal change, and the resident preferences were not being honored in the facility because staff did not make attempts to notify residents when there was a menu change. The facility policy titled Food and Nutrition Service Menus, last revised on December 2023, documented the facility was to assure menus were developed and prepared to meet the nutritional needs of the residents and resident choices including the resident nutritional, religious, cultural, and ethnic needs whild using established national guidelines. Menus that differed from what was being served on the planned menu, would be changed on the food menu, documented in the kitchen on the menu and/or in the record book to record such changes.The posted menu in the kitchen documented residents were to receive waffles, warm syrup, breakfast meat, hot or cold cereal, and milk/juice for breakfast on 12/10/2025.The facility policy titled Resident Rights:, dated October 4, 2016, documented residents had the right to make choices about aspects of their life in the facility that were significant to the individual. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and document review, the facility failed to ensure an opened bottle of hand sanitizer was removed from a resident food storage area. This deficient practice had the potential to affect all residents in the facility by increasing the risk of food contamination and illness.Findings include:On 12/08/2025 at 8:23 AM, an open bottle of FLTR Pure Protectant hand sanitizer gel (75% ethyl alcohol, 16.9 fluid ounces) was observed on a shelf in the resident food storage area. The hand sanitizer was placed on a tray with a coffee pot, cups, creamer, and sugar.On 12/08/2025 at 8:25 AM, the [NAME] confirmed an open bottle of hand sanitizer was being stored with the resident dry food. The [NAME] explained the hand sanitizer was kept on a tray containing a coffee pot, and accessories to serve hot coffee to residents, because when staff would take the tray out into the hallways, if residents wanted coffee, staff were using the hand sanitizer prior to giving the residents coffee. The cook verbalized chemicals were not to be stored with food to be served to residents.The facility policy titled Dietary Services, last revised August 2007, documented food storage areas would be maintained in a clean, safe, and sanitary manner. Toxic substances were not to be stored in the kitchen area or store rooms for food. |

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| Rosewood Rehabilitation Center | 2045 Silverada Blvd<br>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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**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 resident information was not visible on an unattended computer screen at a nursing station facing a public area. This deficient practice had the potential to result in unauthorized access to residents' Protected Health Information (PHI).Findings include:On 12/09/2025 at 10:01 AM, a nurse walked away from the medication cart and left a computer screen open displaying resident information, including medications for the resident in room [ROOM NUMBER]-B.On 12/09/2025 at 10:03 AM, one staff member walked by the unlocked computer screen.On 12/09/2025 at 10:05 AM, the nurse walked behind the nurse's station.On 12/09/2025 at 10:05 AM, the Licensed Practical Nurse (LPN) returned to the medication cart. When asked if the computer should have been locked prior to leaving the cart, the LPN verbalized, I guess so, and explained locking the computer when walking away was required to protect PHI under Health Insurance Portability and Accountability Act (HIPAA).On 12/09/2025 at 10:46 AM, the Director of Nursing (DON) stated that the expectation was for nurses to lock the medication cart, lock the computer screen, and ensure all paperwork was turned over to hide resident information.Review of the facility policy titled HIPAA Privacy and Security Operational Guide, undated, documented that to protect PHI, staff were required to lock medication cart computers when not in use. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 295020 | A. Building<br>B. Wing | 12/11/2025 |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement a program that monitors antibiotic use.<br><br>Based on interview and document review, the facility failed to ensure education regarding the facility's Antibiotic Stewardship Program (ASP) was provided to residents and residents' representatives/families. This deficient practice had the potential to affect all residents in the facility and placed residents at risk of developing antibiotic-resistance. Findings include:On 12/11/2025 at 12:04 PM, the IP verbalized the purpose of the IP role was to facilitate the infection control program and provide education regarding the facility's policies and infection control plan. The IP explained if an antibiotic was prescribed for a resident, the IP would visit the resident and provide education regarding the facility's ASP. The IP would later call the resident's representative/family member to provide education regarding the ASP. The IP explained the education was provided verbally and denied the IP had documented evidence the IP provided the education.The IP confirmed education regarding the ASP was only provided to residents and representatives/families of residents who were prescribed an antibiotic. The IP explained the IP's plan going forward was to educate all residents and resident representatives/families on the ASP however, the education was not currently being provided.The facility policy titled Antibiotic Stewardship, reviewed 04/2025, documented the facility would implement an Antibiotic Stewardship Program (ASP) to promote appropriate use of antibiotics. Education opportunities as identified by the QAPI committee, should be provided for clinical staff as well as residents and their families on appropriate use of antibiotics.A facility document Job Description - Infection Preventionist, signed by the IP on 09/22/2025, documented the primary purpose of the job position was to plan, organize, develop, and direct the infection control program and its activities in accordance with federal, state and local standards, and regulations. Essential duties and responsibilities included ensuring the facility was in compliance with Centers for Disease Control and Prevention (CDC) concerning infection control. To perform the job successfully, the IP must be able to perform each essential duty satisfactorily.The CDC document titled The Core Elements of Antibiotic Stewardship for Nursing Homes, 2015, documented the CDC recommended all nursing homes takes steps to improve antibiotic prescribing practices and reduce inappropriate use as harm from antibiotic overuse was significant for the frail and older adults receiving care in nursing homes. Seven core elements were necessary for implementing a successful ASP and included providing educational resources to clinicians, nursing staff, residents and families about antibiotic resistance and opportunities for improving antibiotic use. Nursing homes engaged residents and their family members in antibiotic use and stewardship educational efforts to ensure clinicians had their support to make appropriate antibiotic use decisions. Cross reference tag F882. |

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| F 0943<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.<br><br>Based on employee record review, document review and interview, the facility failed to ensure an employee completed training on preventing, identifying, and reporting abuse, neglect, misappropriation of property, and exploitation (abuse training) for 1 of 20 sampled employees (Employee #11). The deficient practice had the potential to place residents at risk for abuse and neglect. Findings Include: Employee #11 Employee #11 had a title of Licensed Practical Nurse (LPN) and a hire date of 04/01/2025. Employee #11's record lacked documented evidence abuse training had been completed. On 12/10/2025 at 12:37 PM, the Human Resources Payroll Representative confirmed Employee #11 had worked 29 shifts as a contract LPN and had not completed abuse training, as required. The Human Resources Payroll Representative verbalized having been responsible for ensuring contract employees obtained the required abuse training but did not ensure the training was completed. The facility policy titled, Freedom from Abuse, Neglect, Exploitation, revised 10/2022, documented staff would receive training related to the prohibition and prevention, identifying and recognizing, and reporting of resident abuse, neglect, misappropriation of property, and exploitation. |

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| F 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>Based on observation and interview, the facility failed to ensure current nursing hours were posted for the facility. This deficient practice had the potential to result in a lack of awareness for residents and visitors regarding the number of nursing staff on duty.Findings include:On 12/11/2025 at 9:23 AM, the nursing staff posting for the facility was dated 12/10/2025.On 12/11/2025 at 9:25 AM, the Administrator confirmed the nursing staff posting in the facility was for 12/10/2025. The Administrator verbalized that the posting should be updated first thing at the start of the shift when staff arrive. |

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| F 0838<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | 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.<br><br>Based on interview and document review, the facility failed to ensure the Facility Assessment included staffing requirements based on the average census of the facility. The deficient practice could result in the facility not being able to determine what resources were necessary to care for its residents competently.Findings include:The Facility assessment dated 2025, lacked documented evidence for adequate staffing levels related to the average census of the facility.On 12/11/2025 at 8:26 AM, the Administrator confirmed the Facility Assessment staffing plans did not include an average census and staffing levels per shift to be able to meet the care needs of each resident.The facility policy titled Facility Assessment, originally dated 10/2017, documented staffing decisions were determined at the facility level to ensure there were enough staff with appropriate competencies and skill sets necessary to care for residents' needs as identified through resident assessments and plans of care. |