STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295023	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northstar Post Acute	2898 Highway 50 East Carson City, NV 89701

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on record review and interviews, the facility failed to effectively and efficiently manage operations to ensure the agency staff received training and orientation on facility policies, procedures, and resident care expectations prior to being assigned to provide care. This deficient practice resulted in agency staff delivering care without demonstrating competency or knowledge of critical safety policies (including infection control, abuse reporting, emergency procedures, and proper use of care equipment), placing residents at risk for compromised quality of care and safety. Findings included:On 01/28/2026 and 02/02/2026, during personnel record review, the State surveyor requested documentation of training provided to agency staff prior to assignment on the units. The facility was unable to provide evidence of comprehensive orientation or competency-based training for agency staff to include elder abuse training, dementia care training, Quality Assurance and Performance Improvement (QAPI) training, communication training, resident rights, infection control training, and compliance and ethics training. On 01/28/2026 at 12:54 PM, the Administrator verbalized the facility kept a contract with an outside agency to obtain staff for uncovered shifts. The Administrator explained the contract indicated all staff provided would have the training required for their individual certifications; however, was unable to confirm whether agency staff completed the training required for a position in a skilled nursing facility. The Administrator explained the facility did not retain personnel records for agency staff to include behavioral health training related to dementia and abuse prevention training. On 01/29/2026 at 1:50 PM, the Administrator explained the facility did not keep personnel files for agency staff. The Administrator verbalized when new agency staff came to the facility, the staff oriented the agency staff to this is A hall, this is B hall, and here's the administrator office, etc. The Administrator confirmed the facility did not have an orientation training program for agency staff. On 02/02/2026 at 2:30 PM, the Administrator verbalized training for QAPI, communication, resident rights, infection control, and compliance and ethics were completed all the time throughout the year. The staff completed orientation training upon hire and went through the training before working on the floor with residents. The Administrator explained agency staff did not go directly through the facility to complete the required training before working on the floor with residents. The Facility Assessment Tool, dated 08/01/2025, documented the purpose of the assessment determined what resources were necessary to care for resident competently during both day-to-day operation and emergencies. The facility used this assessment to make decisions about the direct care staff needs, as well as the capabilities to provide services to the residents in the facility. Using a competency-based approach focused on ensuring each resident was provided care allowing the resident to maintain or attain their highest practicable physical, mental and psychosocial well -being.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review, the facility failed to ensure residents were offered and administered influenza (flu) or pneumococcal (PNA) vaccinations as required by facility policy for 12 of 12 residents reviewed for vaccination compliance (Residents #6, #19, #24, #5, #3, #7, #37, #8, #53, #9, #10, and #1). This deficient practice had the potential to result in residents contracting a preventable disease and resulting in prolonged illness and debilitation.Findings include:Resident #6Resident #6 was admitted to the facility on [DATE], with diagnoses including acute respiratory failure with hypoxia and chronic obstructive pulmonary disease, unspecified.Resident #19Resident #19 was admitted to the facility on [DATE], with diagnoses including unspecified asthma, uncomplicated and immunodeficiency due to conditions classified elsewhere.Resident #24Resident #24 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including acute respiratory failure with hypoxia and acute respiratory failure with hypercapnia.Resident #5Resident #5 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including immunodeficiency due to conditions classified elsewhere and chronic kidney disease, stage 1.Resident #3Resident #3 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic systolic (congestive) heart failure and dependence on supplemental oxygen.Resident #7Resident #7 was admitted to the facility on [DATE], with diagnoses including chronic obstructive pulmonary disease, unspecified and chronic respiratory failure with hypoxia.Resident #37Resident #37 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary disease, unspecified and immunodeficiency due to conditions classified elsewhere.Resident #8Resident #8 was admitted to the facility on [DATE], with diagnoses including unspecified asthma, uncomplicated and heart failure, unspecified.Resident #53Resident #53 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Alzheimer's disease with late onset and immunodeficiency due to conditions classified elsewhere.Resident #9Resident #9 was admitted to the facility on [DATE], with diagnoses including multiple sclerosis, unspecified and chronic obstructive pulmonary disease, unspecified.Resident #10Resident #10 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including acute on chronic systolic (congestive) heart failure and chronic respiratory failure with hypoxia.Resident #1Resident #1 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including extradural and subdural abscess, unspecified and long term (current) use of anticoagulants.On 01/29/2026 at 10:00 AM, the Infection Preventionist (IP) verbalized screening for flu and PNA vaccines had not been completed as required and the IP was aware of the issue. The IP verbalized the lack of vaccination screening and administration was a widespread concern.On 01/29/2026 at 3:11 PM, the clinical records, including immunization administration documentation, for the residents were reviewed with the Director of Clinical Operations and the IP for compliance with screening and administration of flu and PNA vaccinations. The following was confirmed:Resident #6 was not offered or administered the flu vaccine.Resident #19 was not offered or administered the flu vaccine.Resident #24 was not offered or administered the flu or PNA vaccine.Resident #5 was not offered or administered the flu or PNA vaccine.Resident #3 was not offered or administered the flu or PNA vaccine.Resident #7 was not offered or administered the flu vaccine.Resident #37 was not offered or administered the flu vaccine.Resident #8 was not offered or administered the flu vaccine.Resident #53 was not offered or administered the flu or PNA vaccine.Resident #9 was not offered or administered the flu or PNA vaccine.Resident #10 was not offered or administered the flu vaccine.Resident #1 was not offered or administered the flu vaccine.The facility policy titled Vaccination of Residents, dated 2001, documented all residents would be offered vaccines to aid in preventing infectious diseases. Prior to receiving vaccination, the resident or legal representative would be provided information and education regarding the benefits (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and potential side effects of the vaccinations. Provision of such education would be documented in the residents' medical records.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review, the facility failed to ensure physician visits were completed timely for 5 of 15 sampled residents (Resident #37, #24, #53, #11 and #5). This deficient practice has the potential to result in delayed assessment and management of residents' medical conditions, which could lead to adverse health outcomes. Findings included:Resident #37 Resident #37 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including depression, unspecified, other specified anxiety disorder, and insomnia, unspecified. The clinical record for Resident #37 lacked documented evidence the physician had completed a 30 day in person visit since admission on [DATE]. Resident #24 Resident #24 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including metabolic encephalopathy, acute kidney failure, and acute respiratory failure. The clinical record for Resident #24 lacked documented evidence the physician had completed a 30 day in person visit since admission on [DATE]. Resident #53 Resident #53 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Alzheimer's disease with late onset and personal history of transient ischemic attack and cerebral infarction without residual deficits. The clinical record for Resident #53 lacked documented evidence the physician had completed a 30 day in person visit since admission on [DATE]. Resident #11 Resident #11 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including mild cognitive impairment, essential hypertension and polyneuropathy. The clinical record for Resident #11 documented a physicians visit completed on 06/19/2025 and on 12/25/2025. Resident #11's clinical record lacked documented evidence of a physician 60 day in person visit between July 2025 and November 2025. Resident #5 Resident #5 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including alcoholic cirrhosis of the liver, chronic kidney disease, and alcohol dependence with alcohol - induced dementia. The clinical record for Resident #5 lacked documented evidence the physician had completed a 30 day in person visit since admission on [DATE]. On 02/02/2026 at 12:42 PM, the Administrator verbalized the physician sees the residents at their discretion and there was nothing specific on how often they have to see the residents. On 02/02/2026 in the afternoon, the Director of Nursing (DON) and Director of Clinical Operations (DCO) explained the physicians complete the initial encounters upon admission. The DON and the DCO were unaware of the regulation requirement for physician visits. The DON and the DCO confirmed the in-person physician visits were not completed for Resident #37, #24, #53, #11 and #5. The facility policy titled Physician Services, undated, documented the medical care of each resident was supervised by a licensed physician. The physician visits, frequency of visits, and emergency care of residents were provided in accordance with current OBRA regulation and facility policy.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, interview, and document review, the facility failed to ensure Controlled Drug Records (CDR) were completed in a timely manner to provide accurate reconciliation of controlled medications for 5 of 11 residents (Resident #51, #4, #52, #37, and #10) documented in the B wing Controlled Substance logbook. This deficient practice had the potential to result in inaccurate medication accountability, delayed identification of discrepancies, and increased risk of medication diversion or resident harm. Findings include: Resident #51 Resident #51 was admitted to the facility on [DATE], with a diagnosis of Parkinson's disease without dyskinesia, without mention of fluctuations. A physician order dated 10/02/2025, documented pregabalin 50 milligram (mg) capsule, give 50 mg by mouth three times a day for nerve pain. Resident #51's CDR for pregabalin 50 mg capsules documented four capsules were remaining when only three capsules of the medication were available for administration. On 01/29/2026 at 11:31 AM, a Registered Nurse (RN) explained the nurse administered pregabalin to Resident #51at 8:59 AM, and had not entered the administration in the resident's CDR. The RN verbalized it was the RN's routine to wait until the end of the nurse's shift to complete each resident's CDR. The RN confirmed pregabalin was administered to Resident #51 and the nurse did not document the administration in the resident's CDR. Resident #4 Resident #4 was admitted to the facility on [DATE], with diagnoses including unilateral primary osteoarthritis, right knee, spinal stenosis, cervical region, acquired absence of other left toe(s), and other chronic pain. A physician order dated 01/22/2026, documented morphine sulfate 15 mg extended release (ER) tablet. Give 30 mg by mouth every 12 hours for moderate to severe pain, hold for somnolence. Resident #4's CDR for morphine sulfate 15 mg tablets documented there were 23 tablets when only 21 tablets of the medication were available for administration. On 01/29/2026 at 11:54 AM, the Director of Nursing (DON) confirmed the documented amount of remaining morphine sulfate 15 mg ER tablets did not match the actual amount of the medication available for administration. Resident #52 Resident #52 was admitted to the facility on [DATE], with diagnoses including pain due to internal orthopedic prosthetic devices, implants and grafts, subsequent encounter, pain in right hip, and other chronic pain. A physician order dated 01/08/2026, documented oxycodone HCL 5 mg oral tablet. Give 5 mg by mouth every four hours as needed for severe pain (6-10 on a numerical pain scale of 0-10). Resident #52's CDR for oxycodone 5 mg tablets documented there was one tablet when zero tablets of the medication were available for administration. On 01/29/2026 at 11:58 AM, the RN confirmed the CDR documented one 5 mg tablet of oxycodone was available for administration when there were zero tablets of the medication available for administration. Resident #37 Resident #37 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including epileptic seizures related to external causes, not intractable, without status epilepticus, and other specified anxiety disorders. A physician order dated 11/14/2025, documented lacosamide 50 mg oral tablet. Give 50 mg by mouth two times per day for seizure. Resident #37's CDR for lacosamide 50 mg oral tablet documented there were 16 tablets when only 15 tablets of the medication were available for administration. A physician order dated 01/23/2026, documented clonazepam 0.25 mg disintegrating oral tablet. Give 0.25 mg by mouth every eight hours as needed for anxiety. Resident #37's CDR for clonazepam 0.25 mg disintegrating oral tablet documented there were 26 tablets when only 25 tablets of the medication were available for administration. On 01/29/2026 at 12:01 PM, the RN confirmed Resident #37's CDR for lacosamide documented 16 tablets when only 15 tablets were available and confirmed the resident's CDR for clonazepam documented 26 tablets were available when only 25 tablets of the medication were available for administration. Resident #10 Resident #10 was admitted to the facility on [DATE], with diagnoses including acute on chronic systolic (congestive) heart failure, and ventral hernia without obstruction or gangrene. A physician order dated 12/26/2025, documented (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hydrocodone-acetaminophen 5-325 mg oral tablets. Give one tablet by mouth every six hours as needed for pain. Resident #10's CDR for hydrocodone-acetaminophen 5-325 mg oral tablets documented there were four tablets available when only three tablets were available for administration. On 01/29/2026 and 12:04 PM, the RN confirmed Resident #10's CDR for hydrocodone-acetaminophen documented four tablets were available for administration when only three tablets remained. The RN confirmed there was a total of 11 residents documented in the B wing controlled substance logbook and 5 of the 11 residents' CDRs did not correctly document the amount of medication each resident had available for administration. A facility policy titled Controlled Substances dated 2001, did not include guidance for documenting the administration of controlled substances.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **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 medications were administered with an error rate of less than five percent (5%). There were 33 medication administration opportunities and 14 medication errors, resulting in a medication error rate of 42.42%. This deficient practice had the potential to cause residents to receive incorrect dosages, miss necessary medications, or experience adverse health outcomes, including ineffective treatment and harm.Findings include:Resident #69Resident #69 was admitted to the facility on [DATE], with diagnoses including cellulitis of left lower limb and drug induced constipation.A physician's order dated 01/21/2026, documented sennosides-docusate sodium (Senna Plus) 8.60-50 milligrams (mg). Give two tablets by mouth two times per day for bowel.On 01/29/2026 at 8:13 AM, a Registered Nurse (RN1) was administering morning medications to Resident #69. Resident #69 verbalized the resident did not want to take the Senna Plus tablets. RN1 reached into the medication cup containing the resident's morning medications with a bare/ungloved hand, retrieved the Senna Plus tablets, and administered the remaining medication to Resident #69.On 01/29/2026 at 8:24 AM, RN1 confirmed the nurse had used an ungloved hand to retrieve the unwanted Senna Plus from the cup containing Resident #69's morning medications. The RN was not able to explain how to correctly remove the medication from the cup and was not sure why it was incorrect.On 02/02/2026 at 9:57 AM, the Director of Nursing (DON) verbalized the expectation was gloves would be donned prior to removing a medication from an administration cup containing additional medication to be administered to a resident. The DON confirmed nurses were not to remove medications from a medication cup with bare/ungloved hands and then administer the remaining medications to a resident. The DON explained the concern was infection control related to the risk of cross contaminating the medications.The facility policy titled Administering Medications revised April 2019, documented staff followed established facility infection control procedures such as handwashing and wearing gloves for the administration of medications. Cross Reference with F880Resident #2Resident #2 was admitted to the facility on [DATE], with diagnoses including acute and chronic respiratory failure with hypoxia and localized swelling, mass and lump, lower limb, bilateral.Physician's orders dated 01/17/2026, documented the following medications:-morphine sulfate(concentrate) oral solution 100 milligrams (mg)/ 5 milliliters (ml). Give 0.25 ml via gastric tube (g-tube) every four hours for severe pain and shortness of breath.-Refresh Tears solution 0.5 % (carboxymethylcellulose sodium), instill one drop in both eyes every four hours for dry eyes. A physician's order dated 01/26/2026, documented senna-docusate sodium oral tablet 8.6-50 mg, give one tablet via g-tube one time per day for constipation.On 01/29/2026 at 9:18 AM, RN2 administered the medications to Resident #2. The RN confirmed medications were scheduled to be administered at 8:00 AM and all medications were to be administered within one hour before or one after the scheduled administration time. The RN confirmed the medications were administered late.-Morphine Sulfate, 100 mg/5ml, 0.25 ml administered every four hours.-Sennosides docusate 8.6/50 mg, one tablet, administered daily.-Refresh eye drops, one drop each eye, administered every four hours. Resident #35Resident #35 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic systolic (congestive) heart failure, major depressive disorder, generalized anxiety disorder, aphasia following cerebral infarction, and hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease.Physician's orders dated 10/03/204, documented the following medications:-Amlodipine besylate 10 mg oral tablet. Give 10 mg by mouth one time per day for hypertension. Hold for a systolic blood pressure (SBP) less than (<) 110 or a heart rate (HR) <60.-Furosemide 20 mg oral tablet, give one tablet by mouth one time per day for edema. -Losartan potassium 100 mg oral tablet, give one tablet by mouth one time per day. Hold for SBP < 110 or HR < 60. A physician order dated 10/19/2024, documented multiple vitamin tablet, give (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	one tablet by mouth one time per day for supplementation. Physician's orders dated 11/11/2024, documented the following medications:-duloxetine hydrochloride (HCL) 60 mg, delayed release particles capsule. Give one capsule by mouth one time a day for depression.A physician order dated 05/02/2025, documented chlorpheniramine dextromethorphan (DM) 4-30 mg tablet by mouth two times per day for allergies.A physician order dated 06/15/2025, documented fluticasone propionate suspension 50 micrograms (mcg) per actuation (ACT), one spray each nostril one time per day for allergic rhinitis.A physician's order dated 09/11/2025, documented sennosides-docusate sodium 8.6-50 mg, give two tablets twice per day for constipation, hold for loose stools.Physician's orders dated 09/20/2025, documented the following medications: -Clopidogrel 75 mg oral tab, give one tablet per day for cardiovascular accident-Gabapentin 300 mg oral capsule, give one capsule by mouth two times per day for neuropathic pain.-Magnesium oxide 400 mg oral tablet, give one tablet by mouth one time per day for hypomagnesemia.-Docusate sodium 100 mg oral tablet, give one tablet by mouth two times per day for constipation. Hold for loose stools.A physician order dated 01/28/2026, documented pantoprazole sodium 40 mg, delayed release tablet. Give one tablet by mouth per day for gastro-esophageal reflux disease (GERD) without esophagitis.On 01/29/2026 at 9:37 AM, RN2 was not able to administer Losartan potassium 100 mg oral tabs to Resident #35 due to the medication was not available in the medication cart. RN2 explained the medication was ordered in a timely manner resulting in the medication not being available for administration during the morning medication pass.On 01/29/2026 at 9:50 AM, RN2 administered Resident #35's available morning medications.On 01/29/2026 at 9:53 AM, RN2 confirmed the medications were scheduled to be administered at 8:00 AM, and confirmed the medications were administered late when not administered prior to 9:00 AM.On 02/02/2026 at 9:55 AM, the Director of Nursing (DON) confirmed medications were to be administered within one hour before and after the scheduled medication time. On 02/02/2026 at 9:56 AM, the DON explained medication cards usually had a refill date printed on each card and the expectation was medication would be ordered based on the medication's refill date. If the refill date was not printed on the card, the expectation was the medication would be ordered in a timely manner to prevent the resident from running out of the medication. The DON confirmed medications were to be ordered in timely manner and resident medications should always be available at the time the medication was due for administration. A facility policy titled Administering Medications revised April 2019, documented medications were administered within one hour of their prescribed time.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and document review, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee met quarterly, at a minimum for 2 of 4 quarters reviewed. This deficient practice had the potential to result in widespread resident care and staffing concerns not being identified or addressed and causing residents to suffer actual harm.Findings include:QAPI meeting sign in sheets provided by the facility included sign in sheets for a meeting in August, October, November, and December of 2025.On 02/02/2026 at 4:49 PM, the Administrator verbalized the facility did not have sign-in sheets or evidence of QAPI meetings conducted in the first two quarters of 2025.The facility policy titled Quality Assurance and Performance Improvement (QAPI) Program, dated 2001, documented the committee would meet quarterly and as needed to review reports, evaluate data, and monitor QAPI-related activities and make adjustments to the plan.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on interview, personnel record review, and document review, the facility failed to ensure elder abuse prevention training was completed timely per facility policy for 5 of 20 sampled employees (Employees #11, #12, #14, #16, and #20) and 4 of 9 employees sampled for investigation of complaints (Employees #26, #27, #28, and #29). This deficient practice had the potential to place all residents at risk for abuse and neglect.Findings included:Employee #11 Employee #11 was hired as a Registered Nurse (RN), hire date unknown. Employee #11 lacked a personnel record to include documented evidence of completed behavioral health care training for dementia. Employee #12 Employee #12 was hired as a Licensed Practical Nurse (LPN), hire date unknown. Employee #12 lacked a personnel record to include documented evidence of completed behavioral health care training for dementia. Employee #14 Employee #14 was hired as an LPN on 09/30/2025. Employee #14's personnel record documented elder abuse prevention training completed on 10/06/2025, seven days late. Employee #16 Employee #16 was hired as a Certified Nursing Assistant on 08/01/2025. Employee #16's personnel record documented elder abuse prevention training completed on 08/08/2025, seven days late. Employee #20 Employee #20 was hired as a Housekeeper on 09/24/2025. Employee #20's personnel record documented elder abuse prevention training completed on 12/30/2025, 97 days late. On 01/28/2026 at 12:54 PM, the Administrator verbalized the facility required all staff to complete initial abuse prevention training prior to providing care to residents and annually thereafter to ensure staff were aware of the basic requirements of caring for vulnerable populations. The Administrator explained the facility did not keep track of start dates for the facility employees. Employees #11 and #12 were hired as agency staff and the facility did not maintain a personnel record for agency staff. The Administrator was unsure of the hire and start dates of Employees #11 and #12, however confirmed both employees worked on the floor, with residents in the facility. The Administrator (continued on next page)

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Northstar Post Acute	2898 Highway 50 East Carson City, NV 89701

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Confirmed Employees #14, #16, and #20's personnel records lacked additional abuse prevention training completed prior to the dates above. The facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021, documented staff would be provided orientation and training programs to include topics such as abuse prevention identification and reporting of abuse. The facility policy titled In-Service Training, All Staff, undated, documented all staff must participate in initial orientation and annual in-service training. Required training topics included preventing abuse, neglect, exploitation, and misappropriation of resident property. Employee #26 Employee #26 was hired as an LPN, hire date unknown. The facility lacked a personnel record for Employee #26 to include training related to abuse identification and reporting. Employee #27 Employee #27 was hired as an LPN, hire date unknown. The facility lacked a personnel record for Employee #27 to include training related to abuse identification and reporting. Employee #28 Employee #28 was hired as an LPN, hire date unknown. The facility lacked a personnel record for Employee #28 to include training related to abuse identification and reporting. Employee #29 Employee #29 was hired as an RN, hire date unknown. The facility lacked a personnel record for Employee #29 to include training related to abuse identification and reporting. On 01/29/2026 at 1:50 PM, the Administrator verbalized the facility did not have personnel files and/or documented evidence of Employees #26, # 27, #28, and #29 having received training related to the identification and reporting of abuse and neglect. The facility policy titled Abuse, Neglect, Exploitation, and Misappropriation Prevention Program, undated, documented the program consisted of a facility-wide commitment and resource allocation to support objectives including providing staff orientation and training/orientation programs which included topics such as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior. Complaint 2712728

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to ensure 1) a resident consented to receive psychotropic medications prior to the administration of the medications and the consents accurately documented the correct diagnosis or symptom the medication was prescribed to treat for 2 of 15 sampled residents (Resident #9 and #4) and 2) 1 of 15 sampled residents (Resident #5) and/or the resident's representative consented to the use of a Wander Guard (a device secured to a resident's body or wheelchair which triggered an alarm if the resident attempted to exit the building) prior to the facility's implementation of the device. This deficient practice had the potential to result in a resident receiving a medication without being fully informed of the potential risks of the medication, the resident being denied the right to accept or decline the medication or intervention, a resident being unnecessarily confined within the facility and feelings of isolation.Findings include: Resident #9 Resident #9 was admitted to the facility on [DATE], with diagnoses including anxiety disorder, unspecified and schizophrenia, unspecified. An Order Summary Report and the November 2025 Medication Administration Record (MAR) documented the resident had received the following medications: Mirtazapine 7.5 milligram (mg) tablet, give one tablet by mouth at bedtime for anxiety disorder, unspecified. The order start date was 11/21/2025 and the medication was first administered on 11/21/2025. Olanzapine 10 mg tablet, give 10 mg by mouth at bedtime for dementia in other diseases classified elsewhere, unspecified. The order start date was 11/21/2025 and the medication was first administered on 11/21/2025 and last administered on 11/23/2025. The order was discontinued on 11/24/2025. Olanzapine 5 mg tablet, give 5 mg by mouth at bedtime for schizophrenia. The order start date was 11/24/2025 and the medication was first administered on 11/24/2025. The informed consent for mirtazapine documented the indication for use was major depressive disorder (MDD) and the target behavior for the medication was insomnia. Consent for the medication was received from the resident's representative on 11/22/2025, after the resident had already received the first dose of the medication. The informed consent for olanzapine documented the dose of the medication was 5 mg and the indication for use was MDD with a target behavior of insomnia. Consent for the medication was received from the resident's representative on 11/22/2025, after the resident had already received the medication at a higher dose (10 mg) than the representative had consented for the resident to receive. On 01/28/2026 at 2:07 PM, the Director of Nursing (DON) verbalized a psychotropic consent would include the correct medication, dosage, and rationale for the medication. The DON confirmed the consent for olanzapine was for a dose of 5 mg and the resident received a 10 mg dose on 11/21/2025 through 11/23/2025. The DON verbalized non-pharmacological interventions would not be necessary (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to manage the resident's behaviors. The Director of Clinical Operations (DCO) confirmed the diagnoses in the resident's clinical record did not include MDD or insomnia and the consent should have documented the diagnoses the medication was ordered to treat. The DCO confirmed the resident did not have non-pharmacological interventions care planned or ordered to manage the resident's behaviors documented on the psychotropic consents. The facility policy titled Psychotropic Medication Use, dated 2001, documented residents would not receive psychotropic medications unless the medications were necessary to treat a specific condition documented in the medical record. Prior to initiating the use of psychotropic medication non-pharmacological alternatives would be reviewed with the resident or resident representative. The facility document titled Resident Rights, undated, documented the resident would have the right to be fully informed and refuse treatment. Cross reference with tags F605 and F656 Resident #4 Resident #4 was admitted to the facility on [DATE] and readmitted on [DATE], with a diagnosis of insomnia, unspecified. The physician's order dated 01/15/2026 and the January 2026 MAR, documented the resident had received Zolpidem Tartrate tablet 5 mg, give 5 mg by mouth at verbal bedtime for difficulty sleeping at bedtime. The medication was first administered on 01/15/2026. Resident #4's clinical record lacked documented evidence informed consent for Zolpidem was completed. On 01/29/2026 at 4:08 PM, the DON verbalized consents were required for hypnotic medications. The DON confirmed there was no consent for Resident #4's Zolpidem. The facility policy titled Psychotropic Medication Use, undated, documented prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication the staff and physician would review the following with the resident/representative prior to obtaining documented consent or refusal; non-pharmacological interventions; the indication and rationale for the recommendation; the potential risks and benefits; and the resident's/representative's right to accept or decline the treatment. Cross reference tags F605 Resident #5 Resident #5 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including alcohol dependence with alcohol-induced persisting dementia and alcoholic cirrhosis of liver without ascites. A Physician's Order dated 09/12/2024, documented Wander Guard – check placement every (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shift, left side back of arm of wheelchair. Resident #5's Care Plan lacked documented evidence of a current focus, goal, and interventions related to the use of a Wander Guard. On 01/28/2026 at 3:01 PM, Resident #5 was self-propelling in the resident's wheelchair in the B hallway of the facility. A small, white, plastic device was secured to the left arm of the resident's wheelchair. On 01/28/2026 at 3:07 PM, a Certified Nursing Assistant (CNA) confirmed the CNA was assigned to care for Resident #5. The CNA verbalized the CNA thought the resident had a Wander Guard in place and did not know if the resident had a behavior of wandering and/or exit-seeking. On 01/28/2026 at 3:10 PM, the CNA entered Resident #5's room. Resident #5 was seated in the resident's wheelchair near the resident's bed. The CNA pointed to the small, white, plastic device secured to the left arm of the resident's wheelchair and verbalized the device was a Wander Guard. On 01/28/2026 at 4:21 PM, during an interview with the DON and the DCO, the DON verbalized the facility would use a Wander Guard if, upon assessment, a resident portrayed themselves as someone who was not safe, wandered, or meandered aimlessly. The DCO verbalized the facility utilized an elopement risk tool to assess the resident. The DON explained the facility's process when implementing a Wander Guard included talking to the resident and/or the resident's representative about the device, obtaining consent and securing the device to the resident's body or wheelchair if the resident was wheelchair dependent. The potential risks and benefits of use of a Wander Guard were discussed with the resident/resident representative either verbally or over the phone. The DON confirmed the DON was familiar with Resident #5 and confirmed a Wander Guard was currently being used for the resident. The DON and the DCO reviewed Resident #5's record and denied the DON and the DCO were able to locate documented evidence of informed consent for use of the Wander Guard having been obtained by the facility. On 01/28/2026 at 5:06 PM, the DON verbalized the DON contacted Resident #5's representative following the interview at 4:21 PM and obtained consent for use of a Wander Guard. The DON confirmed the facility did not have documented evidence of a consent prior to 01/28/2026. The facility failed to provide a policy related to use of a Wander Guard prior to the end of the survey as requested. The facility policy titled Resident Rights, undated, documented residents had the right to a dignified existence and self-determination. The facility was to protect and promote the rights of each resident. Residents had the right to be fully informed in a language understood by the resident of the resident's health status, including but not limited to, the resident's medical condition. Residents had the right to participate in planning care and treatment or changes in care and treatment. Cross reference tags F657 and F744.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to provide a homelike environment when 1 of 15 sampled (Resident# 10) expressed concern regarding excessive noise within the resident's room. This deficient practice had the potential to negatively affect the resident's psychosocial wellˆbeing.Findings included:Resident #10Resident #10 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including panic disorder (episodic paroxysmal anxiety), major depressive disorder, recurrent, moderate, and insomnia, unspecified.On 01/27/2026 at 9:26 AM, Resident #10 verbalized concerns about needing a room change due to the roommate's television volume, stating the TV remained on throughout the night. Resident reported informing the Director of Nursing (DON) and the Administrator of the desire to move rooms. During the interview, the roommate's television was observed on and playing at a loud volume audible throughout the room.On 01/27/2026 at 2:04 PM, the resident stated, Nurse staff is aware of the verbal fights we have because the television is so loud, and added, I yelled for the nurse and the head nurse and said I am done.On 01/27/2026 at 3:15 PM, the DON stated no awareness of the resident being unhappy with the room, reporting, We only knew about the last room situation, and if there was a room issue everyone would hear about it. The only thing we have heard is the resident is happy because it is bigger. The DON stated quiet time began at 11:00 PM when residents were expected to lower television volume.Resident record included a behavior note dated 12/17/2025 at 2:12 PM describing two nurses discussing a new room change with Resident #10, who expressed a desire to return to the previous room due to the roommate's loud television. Staff offered solutions such as earphones, which resident declined, stating resident would call 911.A second behavior note dated 12/17/2025 at 5:29 PM indicated Resident contacted 911 due to difficulty breathing. When Emergency Medical Services (EMS) arrived, Resident #10 did not require rescue services and instead expressed a desire for a new room and was unable to stop crying.The facility policy titled Room Change/Roommate Assignment, dated March 2021, documented the resident preferences were taken into account when such changes were considered, and inquiries concerning room changes should be referred to the Administrator.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and document review, the facility failed to ensure 1 of 15 sampled residents (Resident #53) was free from neglect when staff did not reconcile medications from the acute care hospital discharge summary, contact the physician to verify and obtain orders for care and medications, and administer medications during the first two days following admission. This deficient practice had the potential to result in physical and emotional harm to the resident. Findings include:Resident #53Resident #53 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Alzheimer's disease with late onset and personal history of transient ischemic attack and cerebral infarction without residual deficits.An acute care hospital Discharge summary dated [DATE], documented Resident #53 was admitted to the hospital on [DATE] from a behavioral health crisis center for fever and sepsis. The resident was treated with Intravenous (IV) fluids and completed a course of Tamiflu. Discharge diagnoses, assessment and plan included severe dementia and history of cerebrovascular accident (CVA). The resident was to continue all home-based drug regimen. Discharge medications and medication changes documented the resident was to continue taking the following medications:-Cholecalciferol 1000 units. Take one capsule by mouth once daily for vitamin D deficiency.-Clopidogrel (Plavix) 75 milligrams (mg). Take one tablet by mouth once daily for CVA or stroke.-Cyanocobalamin 1000 micrograms (mcg). Take one tablet by mouth once daily for inadequate vitamin B12.-Divalproex delayed release 250 mg. Take one tablet by mouth two times per day.-Donepezil 10 mg. Take one tablet by mouth once daily for Alzheimer's disease.-Finasteride 5 mg. Take one tablet by mouth once daily for 90 days for benign enlargement of prostate.-Lurasidone 20 mg. Take one tablet by mouth daily with dinner for mood disorder.-Melatonin 1 mg. Take 1.5 tablets by mouth at bedtime as needed for trouble sleeping.-Quetiapine 25 mg. Take one tablet by mouth every 12 hours as needed for agitation and inappropriate behavior.-Sertraline 25 mg. Take one tablet by mouth once daily for generalized anxiety disorder.-Tamsulosin 0.4 mg. Take once capsule by mouth nightly at 9:00 PM for 90 days.Resident #53's December 2025 Medication Administration Record (MAR) documented the following order/task: medication reconciliation has been performed for this resident with review of the prior care setting discharge medications, one time only for one day. The start date was 12/30/2025. The MAR lacked documented evidence of the completion of the reconciliation and administration of any medications to Resident #53 on 12/30/2025 and 12/31/2025.A Nurse's Note dated 01/01/2026, documented Resident #53 was readmitted to the facility on [DATE]. Medications verified with Advanced Practice Registered Nurse (APRN), called pharmacy, medications able to be delivered and administered to the resident within a few hours. Resident alert and oriented to self only, needed frequent redirection when out of room and wandered throughout the facility.Resident #53's record lacked documented evidence the resident's medications were reconciled and the physician was contacted by nursing staff to obtain/confirm orders for the medications prior to 01/01/2026.On 01/29/2026 at 10:47 AM, a Registered Nurse (RN) verbalized when a resident was going to be admitted to the facility, someone in the admissions office would notify the nurse of the pending admission. The nurse would receive paperwork from the discharging facility and enter all medication orders into the facility's electronic medical record (EMR) system. The RN explained medications orders for new admissions were entered based on the medication list on the discharge summary from the previous facility.On 01/29/2026 at 4:24 PM, during an interview with the Director of Nursing (DON) and the Director of Clinical Operations (DCO), the DON verbalized neglect occurred when staff knew about an issue and decided not to take action on it. The DON confirmed staff's failure to complete and document assessments according to facility policies, failing to contact the physician when a resident was admitted to the facility, and failure to administer medications to a resident would be considered neglect.The DON verbalized when a resident arrived at the facility, staff (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were to orient the resident to the facility, make the resident comfortable, and assure the facility had anything necessary for the resident's care. The admitting nurse was to complete an assessment and document in the admission database evaluation.The DON and DCO explained reconciliation of mediations from the medication history, admitting orders, previous MAR, and the discharge summary as documented in the facility's policy titled admission Assessment and Follow Up: Role of the Nurse meant the nurse was expected to review the medications being recommended on the discharge summary, bring the list of medications to the physician for review and enter orders into the EMR once approved by the facility's physician. The reconciliation process was expected to be completed upon admission. The DON explained the facility's entire admission process could take up to 24-48 hours; however, the DON verbalized the medication reconciliation with the provider should be completed by the end of the day the resident was admitted to the facility. The DON and DCO verbalized if the physician was not in the facility, the expectation of the admitting nurse was to call the on-call physician to complete the medication reconciliation process. The facility had access to an on-call physician at all times.The DON verbalized if a resident did not receive a recommended anticoagulant it put the resident at risk for adverse effects such as blood clots. The outcome if a resident did not receive a recommended psychotropic medication could be different depending on the resident and what the medication was. For example, if a resident was prescribed an antianxiety medication and did not receive it, the resident could experience increased feelings of anxiety.The DON verbalized Resident #53 was transferred to the hospital on [DATE] due to agitation and aggressive and sexually inappropriate behaviors. Medications prescribed to the resident prior to the transfer included multiple psychotropic medications and Clopidogrel. Resident #53 returned to the facility on [DATE] at 12:09 PM. The DON and DCO reviewed Resident #53's record and confirmed no medications were administered to the resident on 12/30/2025 and 12/31/2025. The DON confirmed the resident had several medications recommended on the discharge summary from the acute care hospital including psychotropics and Clopidogrel. The DON and DCO verbalized the DON and DCO were unaware and did not know why the medications were not entered into the EMR and administered to the resident for two days upon re-admission to the facility.The DON and DCO confirmed the Resident #53's record lacked documented evidence the resident was assessed by a nurse upon return to the facility, the physician was notified of the resident's re-admission, and the medication reconciliation process was completed as expected. The DCO verbalized there was a checklist staff were supposed to follow to ensure this did not happen and the correct process was not followed.The facility document titled admission Checklist, undated, documented all admission orders were to be reviewed with the provider and verified by two nurses. The order summary was to be printed and faxed to the pharmacy. The attached Resident Care Manager (RCM) checklist included verifying the nurse checklist was complete and accurate, verifying medications for accuracy, ensuring the medications were input correctly with all required fields, and verifying medication times.On 02/02/2026 at 11:28 AM, during an interview with the Administrator and the DCO, the Administrator confirmed the Administrator was the facility's Abuse Coordinator. The Administrator verbalized neglect was the willful withholding of services from a resident and willfully ensuring a resident did not receive care. The Administrator confirmed the Administrator was aware of Resident #53 not receiving any medications upon re-admission to the facility and explained after reviewing the incident on 01/29/2026, the Administrator had landed on the incident being an error in documentation.The DCO explained the expectation was for two nurses to reconcile a resident's medications, call the physician to confirm the correct medications were being ordered and enter the medication orders into the facility's EMR system. The DCO verbalized the medications were not populated on the MAR the day Resident #53 re-admitted to the facility.On 02/02/2026 at 1:28 PM, the Administrator confirmed nurses were expected to reconcile residents' medications upon admission and verbalized the nurse missed that the medication reconciliation did not occur for Resident #53 when the resident re-admitted to the facility on [DATE]. The Administrator verbalized it was within the nurse's purview to ensure the facility's admission checklist was (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed and the admission process was followed.The facility policy titled admission Assessment and Follow Up: Role of the Nurse, revised 09/2012, documented the purpose of the procedure was to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for purposes of managing the resident, initiating the care plan, and completing required assessments. Staff were to conduct an admission assessment, conduct a physical assessment, and reconcile the list of medications from the medication history, admitting orders, the previous MAR, and the discharge summary according to established procedures. The attending physician was to be contacted to review the findings of the initial assessment and any other pertinent information and obtain admission orders based on the findings. The date and time the assessments were performed, all relevant assessment data obtained, orders obtained from the physician, and the signature and title of the person recording the data was to be documented in the resident's medical record. The facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, undated, documented residents had the right to be free from abuse, neglect, misappropriation of resident property and exploitation.The facility policy titled Identifying Neglect, undated, documented neglect included cases where the facility's indifference to or disregard for resident care, comfort or safety resulted in or could have resulted in physical harm, mental anguish or emotional distress. Neglect could have been a pattern of failures or the result of one or more failures involving one resident and one staff member. Neglect of goods or services may occur when staff were aware, or should have been aware, of residents' care needs, based on assessment and care planning, but were unable to meet the identified needs due to other circumstances such as lack of training, lack of sufficient staffing, lack of supplies, or lack of staff knowledge of the needs of the resident.Cross reference tags F607 and F609. Complaint 2712728

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to ensure a resident receiving psychotropic medications had non-pharmacological interventions in place to manage the resident's behaviors for 1 of 15 sampled residents (Resident #9) and residents receiving psychotropic medications had adequate monitoring for behaviors and side effects and appropriate indication for usage for 2 of 15 sampled residents (Resident #4 and #37). This deficient practice had the potential to result in a resident receiving unnecessary medications or lack of nonpharmacological interventions resulting in a resident receiving increased doses of psychotropic medications and adverse drug reactions. Findings include: Resident #9 Resident #9 was admitted to the facility on [DATE], with diagnoses including anxiety disorder, unspecified and schizophrenia, unspecified. An Order Summary Report and the November 2025 Medication Administration Record documented the resident had received the following medications: Mirtazapine 7.5 milligram (mg) tablet, give one tablet by mouth at bedtime for anxiety disorder, unspecified. The order start date was 11/21/2025 and the medication was first administered on 11/21/2025. Olanzapine 10 mg tablet, give 10 mg by mouth at bedtime for dementia in other diseases classified elsewhere, unspecified. The order start date was 11/21/2025 and the medication was first administered on 11/21/2025 and last administered on 11/23/2025. The order was discontinued on 11/24/2025. Olanzapine 5 mg tablet, give 5 mg by mouth at bedtime for schizophrenia. The order start date was 11/24/2025 and the medication was first administered on 11/24/2025. The informed consent for mirtazapine documented the indication for use was major depressive disorder (MDD) and the target behavior for the medication was insomnia. Consent for the medication was received from the resident's representative on 11/22/2025, after the resident had already received the first dose of the medication. The informed consent for olanzapine documented the dose of the medication was 5 mg and the indication for use was MDD with a target behavior of insomnia. Consent for the medication was received from the resident's representative on 11/22/2025, after the resident had already received the medication at a higher dose (10 mg) than the representative had consented for the resident to receive. On 01/28/2026 at 2:07 PM, the Director of Nursing (DON) verbalized a psychotropic consent would include the correct medication, dosage, and rationale for the medication. The DON confirmed the consent for olanzapine was for a dose of 5 mg and the resident received a 10 mg dose on 11/21/2025 (continued on next page)

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Northstar Post Acute	2898 Highway 50 East Carson City, NV 89701

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	through 11/23/2025. The DON verbalized non-pharmacological interventions would not be necessary to manage the resident's behaviors. The Director of Clinical Operations (DCO) confirmed the diagnoses in the resident's clinical record did not include MDD or insomnia and the consent should have documented the diagnoses the medication was ordered to treat. The DCO confirmed the resident did not have non-pharmacological interventions care planned or ordered to manage the resident's behaviors documented on the psychotropic consents. The facility policy titled Psychotropic Medication Use, dated 2001, documented residents would not receive psychotropic medications unless the medications were necessary to treat a specific condition documented in the medical record. Prior to initiating the use of psychotropic medication non-pharmacological alternatives would be reviewed with the resident or resident representative. Behavioral and other non-pharmacological approaches would be used to minimize or eradicate the need for medications, permit the lowest possible dose if indicated, and support efforts at gradual dose reduction. Cross reference with tags F552 and F656 Resident #4 Resident #4 was admitted to the facility on [DATE] and readmitted on [DATE], with a diagnosis of insomnia, unspecified. The physician's order dated 01/15/2026 documented Zolpidem Tartrate tablet 5 mg, give 5 mg by mouth at verbal bedtime for difficulty sleeping at bedtime. Resident #4's clinical record lacked documented evidence of behavior monitoring prior to and following initiation of the medication, and side effect monitoring. Resident #37 Resident #37 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including depression, unspecified, other specified anxiety disorder, and insomnia, unspecified. The physician's order dated 11/14/2025 documented Clonazepam oral tablet disintegrating 0.25 mg, give 0.25 mg by mouth every eight hours as needed for F41.8 (ICD-10 International Classification of Diseases, Tenth Revision) other specified anxiety disorders. Resident #37's clinical record lacked documented evidence of behavior monitoring prior to and following initiation of the medication, and side effect monitoring. On 01/29/2026 at 3:45 PM, the DON explained when a resident was prescribed a psychotropic medication the resident would be monitored by clinical nursing staff for behaviors and side effects, and all documentation would be in the resident record. The DON confirmed Resident #4 and #37's clinical record lacked documentation of behavior monitoring and side effect monitoring by clinical nursing staff for the use of psychotropic medications. The DON verbalized psychotropic medications required an indication for usage which would entail (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	something related to the behavior of why the resident would be taking the medication. The DON explained a diagnosis could be used as an indication for usage and staff would know when Resident #37 had anxiety by the resident's sign of worrying and asking the staff constant questions. The facility's policy titled Psychotropic Medication Use, undated, documented residents did not receive psychotropic medications not clinically indicated and necessary to treat a specific condition documented in the medical record. Psychotropic medication management was an interdisciplinary process involving the residents, family and/or the representatives and included determining adequate indication for use, adequate monitoring for efficacy and adverse consequences, and preventing, identifying, and responding to adverse consequences. Cross reference tags F552 and F657

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on interview and document review, the facility failed to ensure the facility did not employ a Registered Nurse (RN) with a disciplinary action against the RN's professional license as a result of a finding of abuse of a patient. This deficient practice placed all residents in the facility at risk for abuse. Findings include:On 01/27/2026, the facility provided a list of current employees of the facility. The list included names, titles, and original hire dates for all employees. The RN of concern was included on the list and had an original hire date of 12/11/2017.The facility schedules for January and February 2026 documented the RN of concern was scheduled to work in the facility.On 02/02/2026, in response to a request for the RN of concern's professional license number, the facility provided a printed copy of a Primary Source Board of Nursing Report Summary for the RN of concern from the Nevada State Board of Nursing's (NV SBON) website. The report documented the RN's license was active and restricted, with discipline. The basis for action was violation code 14, patient abuse, and the initial action date was 09/21/2023.On 02/02/2026 at 1:28 PM, the Administrator who was also the Abuse Coordinator, explained the facility conducted background checks and reviewed professional licenses of individuals upon hire to ensure the facility did not employ anyone with a disciplinary action in effect against a professional license as a result of a finding of abuse. The facility conducted frequent repeat background checks and if there were new actions taken against a professional license the licensing board would contact the facility. The facility would review the information and determine if the staff member's employment could continue.The Administrator/Abuse Coordinator verbalized if the facility was told a nurse or a Certified Nursing Assistant (CNA) willfully participated in abuse, the facility probably wouldn't let the nurse or CNA work in the facility. If the nurse or CNA was already an employee of the facility, the nurse or CNA would be suspended pending the facility's review of the information. The Administrator denied being aware of any disciplinary action against the RN of concern's license related to abuse of a patient.The Administrator reviewed the printed report from the NV SBON's website and confirmed the report documented the RN's license was restricted, with discipline, and the basis for action was violation code 14, patient abuse.On 02/02/2026 at 2:41 PM, during an interview with the Director of Nursing (DON) and the Director of Clinical Operations (DCO), the DCO explained the DON and DCO became aware of discipline against the RN of concern's license at the beginning of August 2025 when the facility was contacted by the NV SBON. The DCO and DON were providing quarterly updates to NV SBON on the RN's attendance and work performance. The DCO and DON confirmed the DCO and DON were aware the disciplinary action against the RN's license was related to a finding of abuse and explained having been aware of the abuse finding for several months.On 02/02/2026 at 3:19 PM, the Administrator verbalized the Administrator's concern regarding someone who had substantiated allegations of physically striking a restrained patient working with residents in the facility who had dementia and/or were vulnerable, would begin and end with the entity responsible for oversight of the investigation of the incident and oversight of the individual. The Administrator verbalized if the board (licensing board) had a concern, the board would have stripped the nurse of their license.The Administrator affirmed the Administrator was able to look up information or question the staff member about the specifics of substantiated findings when the Administrator was notified a staff member had a finding related to abuse on a professional license. The Administrator explained if a licensing board had not barred the nurse from working in the facility and the nurse was cleared through a background check then the Administrator didn't have any more authority than the state. The Administrator stated, at the end of the day, as long as they are honest and working with their licensing body, then that's good enough for me.The facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, undated, documented residents had the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The program consisted of a facility-wide commitment and resource allocation to support the development and implementation of policies and protocols to prevent and (continued on next page)

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identify abuse or mistreatment of residents, conducting employee background checks and not knowingly employing or otherwise engaging any individual who had a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.Complaint 2712728

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interview, and document review, the facility failed to identify and report neglect of a resident to the State Agency (SA) for 1 of 15 sampled residents (Resident #53). This deficient practice had the potential to result in allegations and incidents of possible abuse, neglect, and mistreatment of residents not being investigated by the facility and/or the SA.Resident #53Resident #53 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Alzheimer's disease with late onset and personal history of transient ischemic attack and cerebral infarction without residual deficits.An acute care hospital Discharge summary dated [DATE], documented Resident #53 was admitted to the hospital on [DATE] from a behavioral health crisis center for fever and sepsis. The resident was treated with Intravenous (IV) fluids and completed a course of Tamiflu. Discharge diagnoses, assessment and plan included severe dementia and history of cerebrovascular accident (CVA). The resident was to continue all home-based drug regimen. Discharge medications and medication changes documented the resident was to continue taking the following medications:-Cholecalciferol 1000 units. Take one capsule by mouth once daily for vitamin D deficiency.-Clopidogrel (Plavix) 75 milligrams (mg). Take one tablet by mouth once daily for cerebrovascular accident or stroke.-Cyanocobalamin 1000 micrograms (mcg). Take one tablet by mouth once daily for inadequate vitamin B12.-Divalproex delayed release 250 mg. Take one tablet by mouth two times per day.-Donepezil 10 mg. Take one tablet by mouth once daily for Alzheimer's disease.-Finasteride 5 mg. Take one tablet by mouth once daily for 90 days for benign enlargement of prostate.-Lurasidone 20 mg. Take one tablet by mouth daily with dinner for mood disorder.-Melatonin 1 mg. Take 1.5 tablets by mouth at bedtime as needed for trouble sleeping.-Quetiapine 25 mg. Take one tablet by mouth every 12 hours as needed for agitation and inappropriate behavior.-Sertraline 25 mg. Take one tablet by mouth once daily for generalized anxiety disorder.-Tamsulosin 0.4 mg. Take once capsule by mouth nightly at 9:00 PM for 90 days.Resident #53's December 2025 Medication Administration Record (MAR) documented the following order/task: medication reconciliation has been performed for this resident with review of the prior care setting discharge medications, one time only for one day. The start date was 12/30/2025. The MAR lacked documented evidence of the completion of the reconciliation and administration of any medications to Resident #53 on 12/30/2025 and 12/31/2025.A Nurse's Note dated 01/01/2026, documented Resident #53 was readmitted to the facility on [DATE]. Medications verified with Advanced Practice Registered Nurse (APRN), called pharmacy, medications able to be delivered and administered to the resident within a few hours. Resident alert and oriented to self only, needed frequent redirection when out of room and wandered throughout the facility.Resident #53's record lacked documented evidence the resident's medications were reconciled and the physician was contacted by nursing staff to obtain/confirm orders for the medications prior to 01/01/2026.On 01/29/2026 at 10:47 AM, a Registered Nurse (RN) verbalized when a resident was going to be admitted to the facility someone in the admissions office would notify the nurse of the pending admission. The nurse would receive paperwork from the discharging facility and enter all medication orders into the facility's electronic medical record system. The RN explained medications orders for new admissions were entered based on the medication list on the discharge summary from the previous facility.On 01/29/2026 at 4:24 PM, during an interview with the Director of Nursing (DON) and the Director of Clinical Operations (DCO), the DON verbalized neglect occurred when staff knew about an issue and decided not to take action on it. The DON confirmed staff's failure to complete and document assessments according to facility policies, failing to contact the physician when a resident was admitted to the facility, and failure to administer medications to a resident would be considered neglect.The DON and DCO explained reconciliation of mediations from the medication history, admitting orders, previous MAR, and the discharge summary as documented in (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility's policy titled admission Assessment and Follow Up: Role of the Nurse meant the nurse was expected to review the medications being recommended on the discharge summary, bring the list of medications to the physician for review and enter orders into the EMR once approved by the facility's physician. The reconciliation process was expected to be completed by the end of the day the resident was admitted to the facility. The DON and DCO verbalized if the physician was not in the facility, the expectation of the admitting nurse was to call the on-call physician to complete the medication reconciliation process. The facility had access to an on-call physician at all times.The DON verbalized Resident #53 was transferred to the hospital on [DATE] due to agitation and aggressive and sexually inappropriate behaviors. Medications prescribed to the resident prior to the transfer included multiple psychotropic medications and Clopidogrel. Resident #53 returned to the facility on 12/302025 at 12:09 PM. The DON and DCO reviewed Resident #53's record and confirmed no medications were administered to the resident on 12/30/2025 and 12/31/2025. The DON confirmed the resident had several medications recommended on the discharge summary from the acute care hospital including psychotropics and Clopidogrel. The DON and DCO verbalized the DON and DCO were unaware and did not know why the medications were not entered into the EMR and administered to the resident for two days upon re-admission to the facility.The DON and DCO confirmed Resident #53's record lacked documented evidence the resident was assessed by a nurse upon return to the facility, the physician was notified of the resident's re-admission, and the medication reconciliation process was completed as expected. The DCO verbalized there was a checklist staff were supposed to follow to ensure this did not happen and the correct process was not followed.The facility document titled admission Checklist, undated, documented all admission orders were to be reviewed with the provider and verified by two nurses. The order summary was to be printed and faxed to the pharmacy. The attached Resident Care Manager (RCM) checklist included verifying the nurse checklist was complete and accurate, verifying medications for accuracy, ensuring the medications were input correctly with all required fields, and verifying medication times.On 02/02/2026 at 11:28 AM, during an interview with the Administrator and the DCO, the Administrator confirmed the Administrator was the facility's Abuse Coordinator and verbalized neglect was the willful withholding of services from a resident and willfully ensuring a resident did not receive care. The facility protected residents while investigating possible incidents of abuse, neglect, mistreatment, or misappropriation of property by separating the residents if the incident was resident-to-resident or separating the staff member from the resident in the event of a staff-to-resident incident. The Administrator would then proceed with an investigation. The Administrator verbalized the Administrator waited to report incidents to the SA and would not report incidents to the SA until the Administrator understood what the issue was. Understanding what the issue was involved but was not limited to talking to staff and residents. The Administrator confirmed the Administrator was aware of a concern involving Resident #53 not receiving medications upon re-admission to the facility.On 02/02/2026 at 1:28 PM, the Administrator confirmed the Administrator believed neglect was the willful withholding of services and willfully ensuring a resident did not receive care. The Administrator explained staff's action or inaction was not considered neglect when staff forgot something. The Administrator confirmed nurses were expected to reconcile residents' medications upon admission and verbalized it was within the nurse's purview to ensure the facility's admission checklist was completed and the admission process was followed. The Administrator verbalized the nurse missed that the medication reconciliation did not occur for Resident #53 when the resident re-admitted to the facility.The Administrator recalled the Administrator was first made aware on 01/06/2026 of Resident #53 did not receive medications on 12/30/2025 and 12/31/2025 by a floor supervisor. The Administrator denied the incident was reported to the SA and denied the incident was investigated for possible neglect as the Administrator did not suspect abuse or neglect had occurred.The facility policy titled admission Assessment and Follow Up: Role of the Nurse, revised 09/2012, documented the purpose of the procedure was to gather information about the resident's physical, emotional, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognitive, and psychosocial condition upon admission for purposes of managing the resident, initiating the care plan, and completing required assessments. Staff were to conduct an admission assessment, conduct a physical assessment, and reconcile the list of medications from the medication history, admitting orders, the previous MAR, and the discharge summary according to established procedures. The attending physician was to be contacted to review the findings of the initial assessment and any other pertinent information and obtain admission orders based on the findings. The date and time the assessments were performed, all relevant assessment data obtained, orders obtained from the physician, and the signature and title of the person recording the data was to be documented in the resident's medical record.The facility policy titled Identifying Neglect, undated, documented employees and contractors hired by the facility were expected to be able to identify neglect as it may occur to residents. Preventing neglect was a priority throughout all levels of the organization and included recognizing and understanding how neglect was defined. Neglect included cases where the facility's indifference to or disregard for resident care, comfort or safety resulted in or could have resulted in physical harm, mental anguish or emotional distress. Neglect could have been a pattern of failures or the result of one or more failures involving one resident and one staff member. Neglect of goods or services may occur when staff were aware, or should have been aware, of residents' care needs, based on assessment and care planning, but were unable to meet the identified needs due to other circumstances such as lack of training, lack of sufficient staffing, lack of supplies, or lack of staff knowledge of the needs of the resident.The facility policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised 04/2021, documented if resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source was suspected, the suspicion was to be reported immediately to the Administrator and to other officials according to state law. The Administrator or the individual making the allegation immediately reports the suspicion to the state licensing/certification agency responsible for surveying/licensing the facility. Immediately was defined as within two hours of an allegation involving abuse or resulting in serious bodily injury or within 24 hours if the allegation did not involve abuse or result in serious bodily injury. A written report of the findings of the investigation would be provided to appropriate agencies within five working days of the incident. Cross reference tags F600, F606. Complaint 2712728

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interview, and document review, the facility failed to ensure a thorough investigation was conducted and documentation was completed and/or retained for 1 unsampled resident (Resident #71) who eloped from the facility. This deficient practice had the potential to result in psychosocial and physical harm to residents. Findings include:Resident #71Resident #71 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.An Interdisciplinary Team (IDT) post incident review note, dated 10/29/2024, documented on the morning of 10/27/2024 at 7:30 AM, Resident #71 was noted to be missing from the facility. The resident had a history of wandering. On 10/27/2024 at 5:30 PM the resident was found and taken to an emergency room (ER) for evaluation. The IDT met and it was determined due to the resident's daily habits of wandering and exiting the facility Resident #71 needed to be in a locked unit.On 01/29/2026 at 4:38 PM, the Administrator confirmed the facility lacked documentation an investigation was completed when Resident #71 eloped from the facility during October 2024.The facility policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating revised April 2021, documented all reports of resident abuse/neglect were thoroughly investigated by facility management and all findings of the investigations were documented.Complaint 2296764Cross reference with F689

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to ensure a resident's behaviors were care planned with non-pharmacological interventions and a resident care plan was implemented to ensure residents were able to smoke independently and safely for 2 of 15 sampled residents (Resident #9 and #7). This deficient practice had the potential to result in a resident not receiving the necessary care to alleviate behavioral symptoms of psychiatric diagnoses and causing unnecessary pain and suffering and a resident suffering physical harm from smoking related injuries. Findings include: Resident #9 Resident #9 was admitted to the facility on [DATE], with diagnoses including anxiety disorder, unspecified and schizophrenia, unspecified. An Order Summary Report and the November 2025 Medication Administration Record documented the resident had received the following medications: Mirtazapine 7.5 milligram (mg) tablet, give one tablet by mouth at bedtime for anxiety disorder, unspecified. The order start date was 11/21/2025 and the medication was first administered on 11/21/2025. Olanzapine 10 mg tablet, give 10 mg by mouth at bedtime for dementia in other diseases classified elsewhere, unspecified. The order start date was 11/21/2025 and the medication was first administered on 11/21/2025 and last administered on 11/23/2025. The order was discontinued on 11/24/2025. Olanzapine 5 mg tablet, give 5 mg by mouth at bedtime for schizophrenia. The order start date was 11/24/2025 and the medication was first administered on 11/24/2025. The informed consent for mirtazapine documented the indication for use was major depressive disorder (MDD) and the target behavior for the medication was insomnia. The informed consent for olanzapine documented the indication for use was MDD with a target behavior of insomnia. On 01/28/2026 at 2:07 PM, the Director of Nursing (DON) verbalized non-pharmacological interventions would not be necessary to manage the resident's behaviors. The Director of Clinical Operations (DCO) confirmed the resident did not have nonpharmacological interventions care planned or ordered to manage the resident's behaviors documented on the psychotropic consents. The facility policy titled Care Plan, Comprehensive Person-Centered, dated 2001, documented a comprehensive, person-centered care plan would include measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs and would be developed and (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	implemented for each resident. Cross reference with tags F552 and F605 Resident #7 Resident #7 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia in other diseases classified elsewhere, mild, with psychotic disturbance, and chronic obstructive pulmonary disease, unspecified. On 01/27/2026 at 9:39 AM, observation of the Resident #7's living area revealed a bedside table containing one and half cigarettes and a disposable lighter. Resident verbalized they were a former smoker. Resident #7's care plan dated 11/21/2025, indicated the resident was able to smoke independently as determined by the interdisciplinary team (IDT). On 01/27/2026 at 2:46 PM, during an interview with the Director of Nursing (DON) and the Administrator, they explained the safety lighter was a device difficult to ignite and required residents to demonstrate the ability to use it during the smoking evaluation. During the same interview, the DON and Administrator stated the IDT could consist of only one team member signing off on a resident's ability to smoke. Per the care plan and smoking policy, the IDT was responsible for ensuring residents were able to smoke independently and safely. Resident #7's record review revealed that on 12/03/2025, a smoking evaluation was completed; however, the section requiring IDT sign-off was incomplete and left blank. The facility policy title Smoking policy, created 8/25/2015, documented the resident was determined safe by the attending physician and DON based on a completed smoking evaluation in resident chart. The facility policy title Care Plan Comprehensive Person-Centered, revised 03/2022, documented the IDT team reviewed and updated the care plan: when there has been a significant change in the resident's condition; when the desired outcome was not met; when the resident has been readmitted to the facility from the hospital stay; and at least quarterly, in conjunction with the required quarterly MDS assessment. Cross reference with tag F689

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Northstar Post Acute	2898 Highway 50 East Carson City, NV 89701

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews and document review, the facility failed to revise and reinitiate the comprehensive care plan to address the continued or renewed use of a psychotropic medication after the care plan was marked resolved for 1 of 15 sampled residents (Resident #37) and the care plan for 1 of 15 sampled residents (Resident #5) included the current use of a Wander Guard. This deficient practice resulted in the resident receiving a psychotropic medication and facility use of a Wander Guard without an active care plan to guide staff interventions, monitoring, and evaluation, placing the resident at risk for unmet needs and adverse outcomes. Findings include: Resident #37 Resident #37 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including depression, unspecified, other specified anxiety disorder, and insomnia, unspecified. Resident #37's clinical record documented a care plan for Clonazepam included behavior monitoring, side effect monitoring, and non-pharmacological interventions. The care plan was marked resolved on 01/23/2026 and lacked evidence the care plan was updated or reinitiated to reflect the ongoing or renewed Clonazepam use. The physician's order originally dated 11/14/2025 and reinitiated on 01/23/2026 documented Clonazepam oral tablet disintegrating 0.25 milligrams (mg), give 0.25 mg by mouth every eight hours as needed for other specified anxiety disorders. Resident #37's Medication Administration Record documented administration after 01/23/2026 on the following days: 01/24/2026 and 01/27/2026. On 01/29/2026 at 3:45 PM, the Director of Nursing (DON) stated the Clonazepam care plan was resolved when the medication was reviewed and was not reinitiated when the new order dated 01/23/2026 was entered. Cross reference tags F605 Resident #5 Resident #5 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including alcohol dependence with alcohol-induced persisting dementia and alcoholic cirrhosis of liver without ascites. A Physician's Order dated 09/12/2024, documented Wander Guard – check placement every shift, left side back of arm of wheelchair. Resident #5's Care Plan lacked documented evidence of a current focus, goal, and interventions related to use of the Wander Guard. A Care Plan Report (documenting current and resolved areas of focus, goals, and interventions) revealed Resident #5 was at risk for wandering/elopement. Interventions included Wander Guard to (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	back left side of seat of wheelchair. The intervention and risk for wandering/elopement were resolved by the DON on 12/05/2025. On 01/28/2026 at 3:01 PM, Resident #5 was self-propelling in the resident's wheelchair in the B hallway of the facility. A small, white, plastic device was secured to the left arm of the resident's wheelchair. On 01/28/2026 at 3:07 PM, a Certified Nursing Assistant (CNA) confirmed the CNA was assigned to care for Resident #5.The CNA verbalized the CNA thought the resident had a Wander Guard in place and did not know if the resident had a behavior of wandering and/or exit-seeking. On 01/28/2026 at 3:10 PM, the CNA entered Resident #5's room. Resident #5 was seated in the resident's wheelchair near the resident's bed. The CNA pointed to the small, white, plastic device secured to the left arm of the resident's wheelchair and verbalized the device was a Wander Guard. On 01/28/2026 at 4:21 PM, the DON verbalized the facility would use a Wander Guard if, upon assessment, a resident portrayed themselves as someone who was not safe, wandered, or meandered aimlessly. The DON confirmed the DON expected use of a Wander Guard to be included in the resident's care plan and explained interventions would include ensuring the device and alarm system were functioning correctly. The DON confirmed the DON was familiar with Resident #5 and confirmed a Wander Guard was currently being used for the resident. The DON and the Director of Clinical Operations (DCO) reviewed Resident #5's record and denied the DON and the DCO were able to locate documented evidence of use of the Wander Guard on the resident's current care plan. On 01/28/2026 at 5:06 PM, the DON verbalized the Wander Guard was previously on Resident #5's care plan and had fallen off. The DON confirmed the information should have remained on the care plan as the device was still in use. The facility failed to provide a policy related to use of a Wander Guard prior to the end of the survey as requested. The facility policy titled Care Plan, Comprehensive Person-Centered, revised 03/2022, documented a comprehensive, person-centered care plan including measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs would be developed and implemented for each resident. The care plan described the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Cross reference tags F552 and F744

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to 1) ensure the smoking evaluation was fully completed by the interdisciplinary team (IDT) as required by facility policy and failed to maintain safe smoking practices by providing adequate supervision to prevent accidents for 1 of 15 sampled residents (Resident #7), resulting in the resident having access to smoking materials and a lighter without documented confirmation of safe smoking ability, placing the resident at risk for injury or fire hazard; and 2) provide the supervision necessary to prevent the elopement of 1 unsampled resident (Resident #71).These deficient practices had the potential to result in physical and emotional harm to both residents. Findings include: Resident #7 Resident #7 was admitted to the facility on [DATE], with diagnoses including Alzheimer's disease, dementia in other diseases classified elsewhere, mild, with psychotic disturbance, and chronic obstructive pulmonary disease, unspecified. On 01/27/2026 at 9:39 AM, observation of the Resident #7's living area revealed a bedside table containing one and half cigarettes and a disposable lighter. Resident verbalized they were a former smoker. On 01/27/2026 at 2:46 PM, during an interview with the Director of Nursing (DON) and the Administrator, they explained the safety lighter was a device difficult to ignite and required residents to demonstrate the ability to use it during the smoking evaluation. During the same interview, the DON and Administrator stated the IDT could consist of only one team member signing off on a resident's ability to smoke. Per the care plan and smoking policy, the IDT was responsible for ensuring residents were able to smoke independently and safely. The Administrator stated the smoking evaluation did not need to be completed in full and only needed to be able to close. However, per the smoking policy, the safe smoking evaluation was required to be fully completed. On 01/27/2026 at 3:33 PM, the DON entered the resident's room to identify smoking paraphernalia. The resident became visibly upset and stated, A man came and took it and gave me this lighter, and I want my old lighter. When shown a picture of the previous lighter, the DON stated, I will have to find out if that is a safety lighter or not. On 01/28/2026 at 2:01 PM, when asked if the DON had found out whether the lighter in the picture was a safety lighter, the DON stated, Yes, the lighter is a safety lighter, sure is. Resident #7's record review revealed that on 12/03/2025, a smoking evaluation was completed; however, the section requiring IDT sign-off was incomplete and left blank. The facility policy title Smoking policy, created 8/25/2015, documented only disposable safety lighter was permitted, all other forms of lighters, including matches, were prohibited. Resident #71 Resident #71 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A care plan regarding the potential risk for elopement related to cognitive deficit and a history of wandering was initiated on 07/18/2024, and last revised on 10/13/2024. Interventions included placing a sensor device to alert staff of exit attempts. The monitor was placed on Resident #71's right ankle. Staff were to respond promptly to alarm activations. The device placement, battery function, and effectiveness were to be checked and/or evaluated. The intervention initiated on 07/18/2024, did not include time frames or frequency related to the monitoring of the device. A care plan titled Elopement Episode documented Resident #71 had a previous elopement from the facility on or about 07/28/2024, the intervention was to recognize any unsafe conditions or escalating patterns. An elopement evaluation dated 07/17/2024, documented Resident #71 wandered aimlessly and the resident's wandering behavior was likely to affect the safety or well-being of the resident. Item 12 was titled Risk for Wandering/Elopement Identified and the response options, including risk for wandering, goals, and interventions was left blank/not completed. The section titled Clinical Suggestions was left blank/not completed. An IDT post incident review note, dated 10/29/2024, documented on the morning of 10/27/2024 at 7:30 AM, Resident #71 was noted to be missing from the facility. The resident had a history of wandering. On 10/27/2024 at 5:30 PM the resident was found and taken to an emergency room (ER) for evaluation. The IDT met and it was determined due to the resident's daily habits of wandering and exiting the facility, Resident #71 needed to be in a locked unit. On 01/29/2026 at 4:45 PM, the Administrator verbalized the incident had occurred during a time the Administrator had not worked at the facility. The Administrator confirmed the Administrator had reviewed documentation in Resident #71's clinical record and confirmed the resident had eloped from the facility on the morning of 10/27/2024. A facility policy titled Wandering and Elopements revised March 2019, documented the facility identified residents at risk of unsafe wandering and strived to prevent harm while maintaining the least restrictive environment. Care plans for residents identified as at risk for wandering and/or elopement included strategies and interventions to maintain the residents safety. Cross reference with F610

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview and document review, the facility failed to ensure interventions implemented to care for a resident with dementia were revised based on assessment of the resident's condition when quarterly elopement and wandering risk assessments for 1 of 15 sampled residents (Resident #5) documented a wander alarm was not indicated and a Wander Guard device remained in use. This deficient practice had the potential to result in a resident being unnecessarily confined within the facility and experiencing feelings of isolation. Findings include:Resident #5Resident #5 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including alcohol dependence with alcohol-induced persisting dementia and alcoholic cirrhosis of liver without ascites.A Physician's Order dated 09/12/2024, documented Wander Guard - check placement every shift, left side back of arm of wheelchair.An Elopement and Wandering Risk Observation/assessment dated [DATE], included instructions to evaluate/assess the resident in the clinical areas listed on the form and if the total score was ten or greater, the resident was considered at risk for wandering or elopement. The form documented the type of assessment was quarterly, and the score documented at the top of the form was six. Section I - Interventions, documented, based on the observation/assessment findings a wander alarm was not indicated for Resident #5.An Elopement and Wandering Risk Observation/assessment dated [DATE], included instructions to evaluate/assess the resident in the clinical areas listed on the form and if the total score was ten or greater, the resident was considered at risk for wandering or elopement. The form documented the type of assessment was quarterly, and the score documented at the top of the form was eight. Section I - Interventions documented based on the observation/assessment findings a wander alarm was not indicated for Resident #5.Resident #5's Care Plan lacked documented evidence of a current focus, goal, and interventions related to use of the Wander Guard.On 01/28/2026 at 12:51 PM, Certified Nursing Assistant 1 (CNA1) verbalized CNA1 was familiar with Resident #5 and denied the resident had behaviors of wandering and/or exit-seeking.On 01/28/2026 at 3:01 PM, Resident #5 was self-propelling in the resident's wheelchair in the B hallway of the facility. A small, white, plastic device was secured to the left arm of the resident's wheelchair.On 01/28/2026 at 3:07 PM, CNA2 confirmed CNA2 was assigned to care for Resident #5. CNA2 verbalized CNA2 thought the resident had a Wander Guard in place and did not know if the resident had a behavior of wandering and/or exit-seeking.On 01/28/2026 at 3:10 PM, CNA2 entered Resident #5's room. Resident #5 was seated in the resident's wheelchair near the resident's bed. CNA2 pointed to the small, white, plastic device secured to the left arm of the resident's wheelchair and verbalized the device was a Wander Guard.On 01/28/2026 at 4:21 PM, the Director of Nursing (DON) verbalized the facility would use a Wander Guard if, upon assessment, a resident portrayed themselves as someone who was not safe, wandered, or meandered aimlessly. The Director of Clinical Operations (DCO) verbalized the facility utilized the Elopement and Wandering Risk Observation/Assessment tool to assess the resident. The DON confirmed the DON was familiar with Resident #5 and confirmed a Wander Guard was currently being used for the resident. The DON and the DCO reviewed Resident #5's record and confirmed the Elopement and Wandering Risk Observation/Assessments dated 09/02/2025 and 12/02/2025 documented a wander alarm was not indicated.A Progress Note dated 01/28/2026 at 5:45 PM, documented a reassessment of need for Wander Guard was performed. Interdisciplinary Team (IDT) determined the Wander Guard was no longer necessary. The resident had not displayed exit-seeking behavior recently, resident and spouse in agreement to remove the Wander Guard. Provider notified of reassessment, new order to remove Wander Guard.On 02/02/2026 at 11:04 AM, the DON explained following the interview on 01/28/2026 at 4:21 PM the DON completed a re-evaluation of Resident #5 and confirmed the Wander Guard was not indicated. The DON verbalized the DON did not know how (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	long the resident had no longer met criteria for the device. The DCO verbalized the need for a Wander Guard was supposed to be reassessed quarterly and as needed, based on the Elopement and Wandering Risk Observation/Assessment.The facility failed to provide a policy related to use of a Wander Guard prior to the end of the survey as requested.The facility policy titled Dementia - Clinical Protocol, revised 11/2018, documented the IDT would identify a resident-centered care plan to maximize remaining function and quality of life for residents with confirmed dementia. The staff were to monitor the resident for changes in condition and decline in function and report findings to the physician. The IDT would adjust interventions and the overall plan depending on the resident's responses to the interventions, progression of dementia, development of new medical conditions or complications, changes in resident or family wishes, and other relevant factors.Cross reference tags F552 and F657.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure: 1) a medication cart containing resident medications was secured, 2) insulin pens for 3 of 15 sampled residents (Resident #4, #69, and #36) were stored separately to prevent cross-contamination; and 3) temperatures for the medication room and medication refrigerator were monitored and documented as required. These deficient practices had the potential to result in unauthorized access to medications, increased risk of medication errors or contamination, and compromised medication integrity, which could negatively impact resident health and safety.Findings include: On 01/26/2026 at 8:29 AM, a medication cart was left unlocked in the B wing hall entrance. On 01/26/2026 at 8:32 AM, a Registered Nurse (RN) returned to the unsecured medication cart and confirmed the cart was left unlocked. The RN confirmed the medication cart was out of direct line of site and it was important to ensure the medication cart was locked to avoid unauthorized access. On 01/28/2026 at 1:59 PM, an RN was sitting at the nursing station with the medication cart unlocked and out of site, around the corner from the nursing station. The RN confirmed the medication cart needed to be locked to ensure no one had access to medications not belonging to them. The RN confirmed not being in site of the medication cart. On 01/28/2026 at 2:02 PM, the Director of Nursing verbalized the expectation was if a nurse walked away from the medication cart, they needed to ensure it was locked. The medication cart should not be unlocked if unattended. It was important to ensure the cart was not left unlocked or unattended in order to avoid residents taking medication not intended for them. The facility policy Storage of Medications, revised 11/2020, documented drugs and biologicals used in the facility were stored in locked compartments. Only people authorized to prepare and administer medications had access to locked medications. Insulin Pens Resident #4 was admitted to the facility on [DATE] and readmitted on [DATE], with a diagnosis of type II diabetes mellitus with diabetic neuropathy, unspecified. Resident #69 was admitted to the facility on [DATE], with a diagnosis of type II diabetes mellitus with a foot ulcer. Resident #36 was admitted to the facility on [DATE] and readmitted on [DATE], with a diagnosis of [NAME].pe II diabetes mellitus with diabetic polyneuropathy On 01/29/2026 at 11:31 AM, nine insulin pens belonging to Residents #4, #69, and #36 were found stored in the same cubby/section of the 300 Hall medication cart and were not stored in plastic bags or other barrier to prevent cross contamination of the pens. Resident #4: one Lantus Solostar 100 units(u) per milliliter (ml) pen, and two Novolin regular flex (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pens. Resident #69: one insulin glargine 100 ml insulin pen, and two insulin lispro pens. Resident #36: one insulin glargine 100 ml/unit pen, and two Novolin regular flex pens 100 units/ml. On 01/29/2026 at 11:31 AM, the Director of Nursing (DON) confirmed the insulin pens belonging to Residents #4, #69, and #36 were being stored together in the same section/cubby of the medication cart and were not separated by plastic baggies or any other form of barrier. The concern with insulin pens being stored together was cross contamination. The facility policy titled Storage of Medications revised November 2020, did not include instructions for the safe storage of medications in a medication cart. Temperature Logs On 01/29/2026 at 1:48 PM, the A Wing temperature control logs used to document the temperature of the medication room, and the medication refrigerator lacked documentation as follows: During the month of December 2025, the temperature of the medication room was not documented on 15 of 62 shifts. During the month of December 2025, the temperature of the medication refrigerator was not documented on 15 of 62 shifts. During the month of January 2026, the temperature of the medication room was not documented on 18 of 56 shifts. During the month of January 2026, the temperature of the medication refrigerator was not documented on 8 of 56 shifts. On 01/29/2026 at 1:55 PM the DON confirmed each shift was responsible for checking the temperatures of the medication room and the medication room refrigerator, documenting the time the temperatures, the time the temperatures were checked and initialing the entry. The facility policy titled Storage of Medications revised November 2020, lacked guidance related to the refrigeration of medications and safe temperatures for the medication room, including monitoring of temperatures and corrective actions to take should the temperatures be out of range.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on observation, interview, clinical record review, and document review, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee maintained an ongoing, facility-wide, and data-driven QAPI program and identified widespread concerns with vaccination programs and employee training and background checks. This deficient practice had the potential to result in residents suffering adverse outcomes and decreased quality of life due to widespread concerns not being identified by the QAPI committee.Findings include:On 02/02/2026 at 4:43 PM, the Administrator verbalized the Infection Preventionist (IP) was a member of the QAPI committee and would discuss concerns with the facility's infection prevention plan with the committee during QAPI meetings and as needed. The Administrator verbalized the QAPI committee was unaware of an issue with the vaccine program until the concern was brought to the facility's attention by a State surveyor on 01/29/2026.On 02/02/2026 at 4:45 PM, the Administrator confirmed Human Resources (HR) was a part of the QAPI committee and would discuss concerns related to HR during QAPI meetings. The Administrator verbalized HR was not involved in employee training requirements and employee training was the responsibility of the Staff Development Coordinator (SDC). The Administrator verbalized the facility did not have an SDC.The facility policy titled Quality Assurance and Performance Improvement (QAPI) Program, dated 2001, documented the facility would develop, implement, and maintain and ongoing, facility-wide, data -driven QAPI program focused on indicators of the outcomes of care and quality of life for residents.Cross reference with tags F883, F940, F941, F942, F943, F944, F945, F946, and F949

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, document review, and interview, the facility failed to ensure appropriate infection control measures were maintained while administering medications to 1 of 15 sampled residents (Resident #69). This deficient practice had an increased risk of infection for residents related to cross contamination during medication administration. Findings included:Resident #69Resident #69 was admitted to the facility on [DATE], with diagnoses including cellulitis of left lower limb and drug induced constipation.A physician's order dated 01/21/2026, documented sennosides-docusate sodium (Senna Plus) 8.60-50 milligrams (mg). Give two tablets by mouth two times per day for bowel.On 01/29/2026 at 8:13 AM, a Registered Nurse (RN) was administering morning medications to Resident #69. Resident #69 verbalized the resident did not want to take the Senna Plus tablets. The nurse reached into the medication cup containing the resident's morning medications with a bare/ungloved hand, retrieved the Senna Plus tablets, and administered the remaining medication to Resident #69.On 01/29/2026 at 8:24 AM, the RN confirmed the nurse had used an ungloved hand to retrieve the unwanted Senna Plus from the cup containing Resident #69's morning medications. The RN was not able to explain how to correctly remove the medication from the cup and was not sure why it was incorrect.On 02/02/2026 at 9:57 AM, the Director of Nursing (DON) verbalized the expectation was gloves would be donned prior to removing a medication from an administration cup containing additional medication to be administered to a resident. The DON confirmed nurses were not to remove medications from a medication cup with bare/ungloved hands and then administer the remaining medications to a resident. The DON explained the concern was infection control related to the risk of cross contaminating the medications.The facility policy titled Administering Medications revised April 2019, documented staff followed established facility infection control procedures such as handwashing and wearing gloves for the administration of medications.Cross Reference with F759

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Northstar Post Acute	2898 Highway 50 East Carson City, NV 89701

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review, the facility failed to ensure residents and staff were screened to receive the Coronavirus (Covid) vaccine for 4 of 5 residents reviewed for Covid vaccination compliance (Residents #24, #3, #8, #10). This deficient practice had the potential to result in residents and staff not having the opportunity to accept the vaccine and potentially suffering severe and prolonged illness, with the risk of spreading to others in the facility, if they contract the virus.:Findings include:Resident #24Resident #24 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including acute respiratory failure with hypoxia and acute respiratory failure with hypercapnia.Resident #3Resident #3 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic systolic (congestive) heart failure and dependence on supplemental oxygen.Resident #8Resident #8 was admitted to the facility on [DATE], with diagnoses including unspecified asthma, uncomplicated and heart failure, unspecified.Resident #10Resident #10 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including acute on chronic systolic (congestive) heart failure and chronic respiratory failure with hypoxia.The clinical records for the residents lacked documentation of screening and education on the 2025/2026 Covid vaccine.On 01/29/2026 at 10:00 AM, the Infection Preventionist (IP) verbalized screening for Covid had not been completed as required and the IP was aware of the issue. The IP verbalized the lack of vaccination screening was a widespread concern with the lack of screening and vaccination administration for residents, and staff had not been screened and offered the Covid vaccine within the last year.The facility policy titled Coronavirus Disease - Infection Prevention and Control Measures, revised 05/2023, documented the facility followed infection prevention and control practices recommended by the Centers for Disease Control and Prevention to prevent the transmission of Covid within the facility. Staff and residents would be encouraged to remain up to date with all Covid vaccines and resources and counseling about the importance of receiving the vaccine would be provided.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on interview and record review, the facility failed to provide an effective training program for agency staff to ensure they were knowledgeable about facility policies and resident care procedures. This deficient practice had the potential to negatively impact the quality of care and safety of residents. Findings included:On 01/28/2026 and 02/02/2026, during personnel record review, the surveyor requested documentation of training provided to agency staff prior to assignment on the units. The facility was unable to provide evidence of comprehensive orientation or competency-based training for agency staff to include elder abuse training, dementia care training, Quality Assurance and Performance Improvement (QAPI) training, communication training, resident rights, infection control training, and compliance and ethics training. On 01/28/2026 at 12:54 PM, the Administrator verbalized the facility kept a contract with an outside agency to obtain staff for uncovered shifts. The Administrator explained the contract indicated all staff provided would have the training required for their individual certifications; however, was unable to confirm whether agency staff completed the training required for a position in a skilled nursing facility. The Administrator explained the facility did not retain personnel records for agency staff to include behavioral health training related to dementia and abuse prevention training. On 01/29/2026 at 1:50 PM, the Administrator explained the facility did not keep personnel files for agency staff. The Administrator verbalized when new agency staff came to the facility, the staff oriented the agency staff to this is A hall, this is B hall, and here's the administrator office, etc. The Administrator confirmed the facility did not have an orientation training program for agency staff. On 02/02/2026 at 2:30 PM, the Administrator verbalized training for QAPI, communication, resident rights, infection control, and compliance and ethics were completed all the time throughout the year. The staff completed orientation training upon hire and went through the training before working on the floor with residents. The Administrator explained agency staff did not go directly through the facility to complete the required training before working on the floor with residents. The Facility Assessment Tool, dated 08/01/2025, documented the purpose of the assessment determined what resources were necessary to care for resident competently during both day-to-day operation and emergencies. The facility used this assessment to make decisions about the direct care staff needs, as well as the capabilities to provide services to the residents in the facility. Using a competency-based approach focuses on ensure each resident was provided care allowing the resident to maintain or attain their highest practicable physical, mental and psychosocial well -being.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on interview, personnel record review, and document review, the facility failed to ensure initial effective communication with residents and family training was completed timely per facility policy for 1 of 19 sampled employees (Employee #11). This deficient practice had the potential to prevent residents with communication needs from attaining or maintaining their highest practicable physical, mental and psychosocial well-being. Findings include:Employee #11 Employee #11 was hired as a Registered Nurse hired on an unknown date. Employee #11's personnel record lacked documented evidence of effective communication with residents and family training completed upon hire. On 02/02/2026 at 2:30 PM, the Administrator confirmed effective communication with residents and family training was required for all employees. The Administrator explained there was orientation training upon hire and go through the training before working on the floor. The agency staff did not go directly through the facility for orientation training. On 02/02/2026 at 3:26 PM, the Administrator confirmed Employee #11's personnel record lacked documented evidence of effective communication with residents and family training completed upon hire and before working on the floor with residents. The facility policy titled, In-Service Training, All Staff, undated, documented all staff must participate in initial orientation and annual in-service training. Training topics could include effective communication with residents and family.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. Based on interview, personnel record review, and document review, the facility failed to ensure initial resident rights and responsibilities training was completed timely per facility policy for 1 of 19 sampled employees (Employee #11). This deficient practice had the potential to prevent residents from being able and encouraged to practice their rights as residents. Findings included:Employee #11 Employee #11 was hired as a Registered Nurse hired on an unknown date. Employee #11's personnel record lacked documented evidence of resident rights training completed upon hire. On 02/02/2026 at 2:30 PM, the Administrator confirmed resident rights and responsibilities training was required for all employees. The Administrator explained there was orientation training upon hire and go through the training before working on the floor. The agency staff do not go directly through the facility for orientation training. On 02/02/2026 at 3:26 PM, the Administrator confirmed Employee #11's personnel record lacked documented evidence of resident rights and responsibilities training completed upon hire and before working on the floor with residents. The facility policy titled, In-Service Training, All Staff, undated, documented all staff must participate in initial orientation and annual in-service training. Training topics could include resident rights and responsibilities.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on interview, personnel record review, and document review, the facility failed to ensure initial Quality Assurance and Performance Improvement (QAPI) training was completed timely per facility policy for 1 of 19 sampled employees (Employee #11). This deficient practice had the potential to put residents at risk of receiving care from employees unaware of facility regulations. Findings include:Employee #11 Employee #11 was hired as a Registered Nurse hired on an unknown date. Employee #11's personnel record lacked documented evidence of QAPI completed upon hire. On 02/02/2026 at 2:30 PM, the Administrator confirmed QAPI was required for all employees. The Administrator explained there was orientation training upon hire and go through the training before working on the floor. The agency staff did not go directly through the facility for orientation training. On 02/02/2026 at 3:26 PM, the Administrator confirmed Employee #11 personnel record lacked documented evidence of QAPI training completed upon hire and before working on the floor with residents. The facility policy titled, In-Service Training, All Staff, undated, documented all staff must participate in initial orientation. Training topics could include elements and goals of the facility QAPI program.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on interview, personnel record review, and document review, the facility failed to ensure initial and annual infection control training was completed timely per facility policy for 3 of 19 sampled employees (Employee #4, #6 and #11). This deficient practice had the potential to put residents at risk of contracting avoidable infections and diseases. Findings include:Employee #4 Employee #4 was hired as the Registered Dietician on 08/16/2021. Employee #4's personnel record documented infection control training completed on 11/20/2024; however, lacked annual training completed for 2025. Employee #6 Employee #6 was hired as the Food Services Supervisor on 08/16/2021. Employee #6's personnel record documented infection control training completed on 11/26/2024; however, lacked annual training completed for 2025. Employee #11 Employee #11 was hired as a Registered Nurse hired on an unknown date. Employee #11's personnel record lacked documented evidence of infection control training completed upon hire. On 02/02/2026 at 2:30 PM, the Administrator confirmed infection control training was required for all employees. The Administrator explained there was orientation training upon hire and go through the training before working on the floor. The agency staff did not go directly through the facility for orientation training. On 02/02/2026 at 3:26 PM, the Administrator confirmed Employee #2, and #12 infection control training was not completed annually in 2025. The Administrator confirmed Employee #11 personnel record lacked documented evidence of infection control training completed upon hire and before working on the floor with residents. The facility policy titled, In-Service Training, All Staff, undated, documented all staff must participate in initial orientation and annual in-service training. Training topics could include infection prevention and control program standards, policies and procedures.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. Based on interview, personnel record review, and document review, the facility failed to ensure initial and annual compliance and ethics training was completed timely per facility policy for 3 of 19 sampled employees (Employee #2, #11 and #12). This deficient practice had the potential to put residents at risk of receiving care from employees unaware of facility regulations. Findings include:Employee #2 Employee #2 was hired as the Director of Nursing on 03/24/2020. Employee #2's personnel record documented compliance and ethics training completed on 10/14/2024; however, lacked annual training completed for 2025. Employee #11 Employee #11 was hired as a Registered Nurse hired on an unknown date. Employee #11's personnel record lacked documented evidence of compliance and ethics training completed upon hire. Employee #12 Employee #12 was hired as a Licensed Practical Nurse hired on an unknown date. Employee #12's personnel record documented compliance and ethics training completed on 10/06/2024; however, lacked annual training completed for 2025. On 02/02/2026 at 2:30 PM, the Administrator confirmed compliance and ethics training was required for all employees. The Administrator explained there was orientation training upon hire and go through the training before working on the floor. The agency staff did not go directly through the facility for orientation training. On 02/02/2026 at 3:26 PM, the Administrator confirmed Employee #2, and #12 Compliance and Ethics training was not completed annually in 2025. The Administrator confirmed Employee #11 personnel record lacked documented evidence of compliance and ethics training completed upon hire and before working on the floor with residents. The facility policy titled, In-Service Training, All Staff, undated, documented all staff must participate in initial orientation and annual in-service training. Training topics could include compliance and ethics program standards, policies and procedures.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on personnel record review, interview, and document review, the facility failed to ensure initial behavioral health care training related to dementia, was completed timely for 4 of 20 sampled employees (Employees #11, # 12, #19, and #20). This deficient practice had the potential to prevent residents with dementia care needs from attaining or maintaining their highest practicable physical, mental, and psychosocial well-being. Findings include:Employee #11 Employee #11 was hired as a Registered Nurse (RN), hire date unknown. The facility lacked a personnel record for Employee #11 to include behavioral health care training for dementia. Employee #12 Employee #12 was hired as a Licensed Practical Nurse (LPN), hire date unknown. The facility lacked a personnel record for Employee #12 to include behavioral health care training for dementia. Employee #19 Employee #19 was hired as a Dietary Aide on 09/02/2025. Employee #19's personnel record documented initial behavioral health care training for dementia completed on 12/25/2025, 84 days late. Employee #20 Employee #20 was hired as a Housekeeper on 09/24/2025. Employee #20's personnel record documented initial behavioral health care training for dementia completed on 12/30/2025, 67 days late. On 01/28/2026 at 12:54 PM, the Administrator verbalized the facility required all staff to complete initial behavioral health training related to dementia as all staff interacted with residents in the facility. Behavioral health training related to dementia was to be completed prior to providing care to residents and annually thereafter to ensure staff were aware of the requirements of caring for vulnerable populations. The Administrator explained Employees #11 and #12 were hired as agency staff and the facility did not maintain a personnel record for agency staff. The Administrator was unsure of the hire or start dates of Employees #11 and #12, however confirmed both employees worked on the floor, with residents in the facility. The Administrator confirmed Employees #19 and #20 completed behavioral healthcare training related to dementia late. The facility policy titled Dementia-Clinical Protocol, revised November 2018, documented nursing assistants would receive initial training in the care of residents with dementia and related behaviors. In-services would be conducted at least annually thereafter. The facility policy titled In-Service Training, All Staff, undated, documented all staff must participate in initial orientation and annual in-service training. Required training topics included behavioral health and dementia management.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on record review and interview, the facility failed to maintain staffing hour records for at least 18 months as required by federal regulation. This deficient practice has the potential to impede the facility's ability to demonstrate compliance with staffing requirements and hinders transparency for regulatory review. Findings include:On 01/28/2026 during record review, the surveyor requested staffing hour records for the last 30 days. The facility provided records for last 30 days. At a later time, the surveyor requested the last 18 months of staffing hour records. No additional documentation was available to demonstrate compliance with the 18-month retention requirement. On 1/29/2026 at 12:17 PM, the Administrator and Director of Clinical Operations (DCO) verbalized the facility did not have the last 18 months for the staffing hour records. The Administrator and the DCS were both unaware of the regulation's requirements.