STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295024	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Manor Skilled Nursing Facility	118 East Haskell St Winnemucca, NV 89445

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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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 50210 Based on interview and document review, the facility failed to ensure Minimum Data Set 3.0 (MDS) assessments were encoded and transmitted timely for November 2024. The deficient practice had the potential to impact resident care by delaying the development and implementation of resident care plans. Findings include: The MDS Submission Report for November 2024, documented 2 of 15 (13.3%) MDS assessments were encoded and transmitted late. On 02/06/2025 at 9:36 AM, the MDS Coordinator verbalized the MDS Coordinator was responsible for completing and submitting the MDS assessments for the facility and confirmed two MDS assessments were completed late for November 2024. The facility policy titled Resident Assessment Process, reviewed 01/14/2025, documented the MDS completion, locking, submission, and transmission of the assessment would be according to the timelines outlines in the Resident Assessment Instrument (RAI) Manual.

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

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on interview, clinical record review, and document review, the facility failed to ensure the accuracy of a Minimum Data Set 3.0 (MDS) assessment for 1 of 12 sampled residents (Resident #10). This deficient practice had the potential for the care plan to omit current needs, services, and monitoring for residents. Findings include: Resident #10 Resident #10 was admitted to the facility on [DATE], with diagnoses including depression, hypertension, hyperlipidemia, and type two diabetes mellitus. A Physician Progress Note dated 10/14/2024, documented Resident #10 had a diagnosis of depression. The resident was not receiving any medication for depression and the physician recommended follow-up with behavioral health if the resident showed any overt signs of depression. A quarterly MDS assessment dated [DATE], Section I - Active Diagnoses, included instructions to check all that apply. Diagnoses of hypertension, hyperlipidemia, and diabetes mellitus were checked with an X. Item I5800 - Depression lacked a checkmark, X, or any other indication the resident had the diagnosis. Section Z, item Z0400, included a signature indicating the facility's MDS Coordinator completed Section I of the MDS assessment. On 02/05/2025 at 1:52 PM, a Licensed Practical Nurse (LPN) confirmed Resident #10 had a diagnosis of depression. The LPN explained Resident #10 was not currently taking any medication for depression and staff were monitoring the resident for any changes in behavior such as being tearful or not wanting to get out of bed. The LPN verbalized Resident #10 had some days when the resident did not want to get out of bed and had to be encouraged by staff to get up. If the resident exhibited any signs or symptoms of depression or changes in behavior, staff would notify the physician. On 02/06/2025 at 11:34 AM, the MDS Coordinator verbalized residents' diagnoses were recorded in section I of the MDS assessment. The MDS Coordinator explained the MDS Coordinator included diagnoses in section I of the assessment based on physician notes completed in the 60 days prior to the assessment date. The MDS Coordinator verbalized Resident #10 had a diagnosis of depression, and the resident had been gradually reduced off of psychiatric medications. The MDS Coordinator reviewed the Physician Progress Note dated 10/14/2024, and confirmed the note documented Resident #10 had a diagnosis of depression. The MDS Coordinator confirmed the MDS assessment dated [DATE], did not document the resident's diagnosis of depression and was inaccurate. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Resident Assessment Process, reviewed 01/14/2025, documented it was the responsibility of each member of the Interdisciplinary Team (IDT) to document all information gathered into the resident's clinical record during the lookback period, so it was a comprehensive, accurate, standardized, and reproducible assessment of the resident's status. The information was then entered into the MDS. Each person completing a section of the MDS attested to its accuracy by electronically affixing a signature to the section. The comprehensive care plan must address all care issues relevant to the individual.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the activities program is directed by a qualified professional. 50210 Based on interview, personnel record review, and document review, the facility failed to employ a trained Activity Coordinator. This deficient practice had the potential to affect resident safety and satisfaction for the entire facility census. Findings include: The personnel roster provided to the State Agency lacked documentation of an Activity Coordinator. On 02/03/2025 at 1:10 PM, the Infection Preventionist/Registered Nurse verbalized the facility did not have a certified Activity Coordinator. An Activity Aide was acting in the Activity Coordinator role and working to complete the required credentials. On 02/06/2025 at 10:35 AM, the Resident Care Coordinator verbalized the previous Activity Coordinator stopped working at the facility around the end of September 2024, and the Activity Aide took on the Activity Coordinator role as soon as the Activity Coordinator left. The Resident Care Coordinator explained since the Activity Coordinator left, the facility had received an elevated number of complaints regarding the activities program. On 02/06/2025 at 11:21 AM, the Human Resources (HR) Manager verbalized the previous Activity Coordinator moved to a new position on 09/09/2024. As a result, the facility hired a Certified Activity Consultant and would be working with the facility remotely. The HR Manager verbalized responsibilities of the Activity Coordinator included attending care plan conferences, organizing and maintaining a safe environment, transporting residents to local appointments, and compiling the monthly program calendar. The HR Manager believed the Activity Consultant acted as the Activity Coordinator; however, the HR Manager verbalized the Consultant had not signed the Activity Coordinator position description, was unsure how the consultant would be aware of the expectations without a signed position description, was unsure whether the Consultant fulfilled the job duties of the Activity Coordinator and confirmed it would be difficult to perform those responsibilities while working remotely. The HR Manager confirmed the Agreement for Activity Consultant referred to the Activity Coordinator as a separate person to receive guidance from the Consultant. The HR Manager also verbalized the Activity Aide was not the Activity Coordinator. An Agreement for Activity Consultant dated 09/06/2024, documented the Activity Consultant would provide the Activity Coordinator with information regarding existing community resources, literature and services which would enhance activity programming. An unsigned facility position description titled, Activity Coordinator, revised 02/16/2024, documented the Activity Coordinator was responsible for all aspects of the activities program including the development and implementation of recreation programs, assessment of resident abilities and needs, compilation of a social program calendar, and transportation of residents to local appointments. (continued on next page)

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The position description lacked language to include the role and responsibilities of a certified Activity Consultant to direct the facility's activities program during the period a new Activity Coordinator was obtaining certification. The Activity Aide and Activity Consultant's personnel records lacked a signed position description for Activity Coordinator. On 02/06/2025 at 12:15 PM, the Activity Consultant explained the Consultant was responsible for reviewing the activity calendar, updating resident care plans, and training and certifying employees for the Activity Coordinator position. The Consultant verbalized the Activity Aide had not completed the required training to be in the Activity Coordinator position and had only begun the training in January 2025, despite being in the role since September 2024. Additionally, the Activities Aide did not have two years of experience in an activities program as required to be a qualified Activity Coordinator. The Consultant verbalized neither the Consultant nor the Activity Aide were the facility's Activity Coordinator and confirmed the Activity Coordinator position remained vacant. An Education Reimbursement Request form dated 11/05/2024, documented the Activity Aide needed the certification to hold the Activity Coordinator position.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 50210 Based on observation and interview, the facility failed to ensure current nursing hours were posted for the facility. This deficient practice had the potential to result in a lack of awareness for residents and visitors regarding the number of nursing staff on duty. Findings include: On 02/04/2025 at 4:42 PM, the nursing staff posting for the memory care unit of the facility was dated 01/23/2025. The unlocked unit of the facility lacked a nursing staff posting. On 02/05/2025 at 11:18 AM, the nursing staff posting for the memory care unit of the facility was dated 01/23/2025. The unlocked unit of the facility lacked a nursing staff posting. On 02/05/2025 at 3:40 PM, the Infection Preventionist/Registered Nurse verbalized nurse staffing hours were to be updated daily at shift change in the facility, for both units to ensure there was enough staff and to inform resident families of facility staffing. On 02/06/2025 at 9:01 AM, the nursing staff posting for both the unlocked and memory care units of the facility were dated 02/05/2025. On 02/06/2025 at 9:06 AM, a Certified Nursing Assistant (CNA) verbalized nurse staffing hours were updated every morning. The CNA confirmed the nurse staffing postings were not updated to reflect the current date.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 49557 Based on observation, interview, and document review, the facility failed to ensure resident information was not visible on an unattended computer screen. This deficient practice had the potential for unauthorized access to residents' protected health information. Findings include: On 02/05/2025 at 7:49 AM, a Licensed Practical Nurse (LPN) was preparing medications for a resident. The LPN was utilizing a stationary (desktop) computer next to the facility's medication dispensing system. The computer and medication dispensing system were in a common area, near the nurses' station, and the computer screen was facing the hallway. The LPN verbalized one of the medications was required to be cut in half and the half tablet not being used was to be discarded in the medication storage room. The LPN took the half tablet, walked away from the computer and entered the medication storage room to dispose of the half tablet. The computer screen was left on and unlocked; resident information was visible on the screen. On 02/05/2025 at 8:05 AM, the LPN began preparing medication for a resident. One of the resident's medications required the tablet to be cut in half. The LPN cut the tablet in half, walked away from the computer and entered the medication storage room to dispose of the half tablet. The computer screen was left on and unlocked; resident information was visible on the screen. On 02/05/2025 at 8:36 AM, the LPN verbalized the LPN usually minimized the window on the computer screen prior to walking away from the workstation. The LPN acknowledged the computer screen was left on and unlocked, with resident information visible, while the LPN went into the medication storage room. The LPN verbalized protected resident health information should always be hidden from view prior to staff walking away from a workstation. On 02/06/2025 at 10:05 AM, the Infection Preventionist/Registered Nurse (IP/RN) verbalized private health information should not be visible when staff walked away from a workstation. The IP/RN explained if a computer screen was left on and unlocked without staff present, residents' private health information was not protected. The IP/RN verbalized private health information was anything showing on the screen when a resident's chart was open. The facility policy titled Workstation Use, reviewed 04/04/2024, documented the facility ensured the security of all electronic protected health information by structuring the access to electronic information through workstations. A workstation was an electronic computing device such as a laptop or desktop computer. Employees found to leave any computer workstation unattended after logging in would be subject to the facility's disciplinary process for suspected breach of patient protected health information.

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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. 49557 Based on observation, interview, and document review, the facility failed to ensure a Licensed Practical Nurse (LPN) donned gloves, according to the facility's policy, prior to removal and placement of transdermal patches. This deficient practice had the potential to transfer bacteria, germs, and residual medication between residents. Findings include: On 02/05/2025 at 8:30 AM, during the morning medication pass, an LPN removed a transdermal patch from a resident's chest. The LPN was not wearing gloves during the removal of the patch and did not perform hand hygiene after removing the patch. On 02/05/2025 at 8:31 AM, the LPN placed a new transdermal patch on the resident's right arm. The LPN was not wearing gloves. On 02/05/2025 at 8:37 AM, the LPN confirmed the LPN was not wearing gloves during the removal and placement of transdermal patches while completing the morning medication pass. The LPN verbalized the LPN should have been wearing gloves since the removed patch had been in contact with the resident's skin and to prevent potential transfer of medication from the patches to the LPN's hands. On 02/06/2025 at 10:05 AM, the Infection Preventionist/Registered Nurse (IP/RN) confirmed nursing staff were expected to perform hand hygiene and wear gloves when removing transdermal patches and when administering topical or transdermal medications to residents. The IP/RN verbalized hand hygiene was required to be performed prior to donning and after doffing gloves. The facility policy titled Transdermal Patch Application, revised 05/19/2024, documented staff were to perform hand hygiene and put on gloves prior to the removal of previously applied transdermal patches and application of new patches. The facility policy titled Hand Hygiene, reviewed 08/13/2024, documented hand hygiene was the single most important strategy to reduce the risk of transmitting organisms from one person to another or from one site to another on the same resident. All staff were to perform hand hygiene before each patient encounter including before donning gloves, after contact with a resident's intact skin, and when moving from a contaminated body site to a clean body site during resident care.