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	04/23/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 ensure an incident of resident-to-resident physical abuse was reported to the State Agency (SA) for 1 of 12 sampled residents (Resident #10). This deficient practice had the potential to result in lack of investigation of alleged incidents of abuse by the facility and/or the SA, placing residents at risk for further abuse.Findings include:Resident #10Resident #10 was admitted to the facility on [DATE], with diagnoses including Alzheimer's disease, unspecified and episodic tension-type headache, not intractable.A nursing progress note dated 11/01/2025, documented Resident #10 was seen by a Certified Nursing Assistant (CNA) slapping another resident. The other resident slapped Resident #10 back. The on-call manager was called with the information. Per the on-call manager, continue to keep residents apart and if the residents were together, staff were to keep the residents in eye sight.A Physician Progress Note dated 11/14/2025, documented Resident #10 was involved in a behavioral disturbance approximately one week prior when Resident #10 began to have words with another resident. A heated exchange led to physical aggression between the two residents and each of the residents was physically striking the other.On 04/22/2026 at 1:22 PM, a Licensed Practical Nurse (LPN) verbalized staff received training annually related to abuse and neglect. If staff observed an incident suspicious for abuse or an allegation of abuse was reported to a staff member, staff were to report the incident/allegation to the Director of Nursing (DON) immediately.On 04/22/2026 at 3:19 PM, the DON denied the facility had anyone designated as the facility's Abuse Coordinator and verbalized the DON was responsible for reporting of incidents and/or allegations of abuse, neglect and exploitation of residents to the SA. Reportable incidents were those resulting in major injuries to a resident and any abuse. The DON explained the DON was ultimately responsible for investigating allegations and/or suspicion of abuse.On 04/23/2026 at 11:19 AM, the DON provided copies of the nursing progress note and physician progress note documenting Resident #10 and another resident were slapping/striking each other. The DON verbalized the DON would probably not consider the incident resident-to-resident abuse as it was mutual combat. If a resident slapped another resident because the resident was confused, it was not a reportable incident. The DON verbalized the DON did not know if either resident involved was assessed for pain, injury or mental anguish following the incident as the DON was unable to locate any documentation of an assessment and explained the DON was not the DON at the time.On 04/23/2026 at 11:38 AM, the Minimum Data Set 3.0 (MDS) Coordinator verbalized there were several categories of abuse including sexual, physical and exploitation. Physical abuse was an altercation between multiple residents or between a resident and staff member or visitor and included hitting and slapping. If an allegation of abuse was reported or staff observed an incident suspicious for abuse the facility would need to investigate the incident, assess the resident/s for injuries, talk to the residents, talk to staff, notify the resident's power of attorney, and ensure the resident/s were safe. The MDS Coordinator confirmed the MDS Coordinator was the facility's DON in November 2025. The MDS Coordinator reviewed the nursing progress note dated 11/01/2025 and denied having been made aware of Resident #10 and another resident slapping (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	each other. The MDS Coordinator confirmed the MDS Coordinator should have been notified at the time of the incident and denied the incident was reported to the SA.The facility policy titled Freedom from Abuse/Abuse Prohibition, revised 01/19/2026, documented residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. Willful meant the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical abuse included hitting, slapping, punching, biting and kicking. Any covered individual (owner, operator, employee, manager, agent, or contractor of the facility) identifying signs of possible abuse would immediately report the signs to the charge nurse. The charge nurse would notify the DON or, in his/her absence, the Chief Nursing Officer and/or the Director of Risk Management. Suspected abuse was to be reported to the SA within two hours after the alleged abuse occurred if it resulted in serious bodily injury or within 24 hours if the events causing the allegation did not involve abuse and did not result in serious bodily injury.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 provide documented evidence a fall resulting in pain, swelling, and a skin tear, with an age-indeterminate fracture identified on post-fall imaging was thoroughly investigated to determine if the incident was a result of neglect for 1 of 12 sampled residents (Resident #10). This deficient practice had the potential to result in physical and/or psychosocial harm to residents due to incidents with the potential to indicate neglect not being thoroughly investigated and documented to ensure appropriate protections were in place to prevent future neglect.Findings include:Resident #10Resident #10 was admitted to the facility on [DATE], with diagnoses including Alzheimer's disease, unspecified and episodic tension-type headache, not intractable.A final Facility Reported Incident (FRI) report submitted by the facility on 03/03/2026, documented the report was related to an incident involving Resident #10 and the incident type was neglect. On 02/25/2026 at 5:25 PM Resident #10 was last seen sitting at the dining room table. A Certified Nursing Assistant (CNA) was at the sink in the dining room with the CNA's back turned to the resident. The CNA heard Resident #10 hit the floor. When the CNA turned around it appeared the resident had attempted to get up and lost footing or got tangled up in the chair in which the resident was sitting. Resident #10 had verbal complaints of pain during the initial assessment, sustained a three-centimeter skin tear to the left elbow, bruising to the left knee and swelling to the left ankle. On 02/26/2026, an x-ray of the resident's left ankle was completed. Results of the x-ray included soft tissue swelling of the ankle, age-indeterminate fracture fragments at the lateral malleolus tip, lateral talus, and extensor digitorum Brevis origin.On 04/22/2026 at 3:19 PM, the Director of Nursing (DON) denied the facility had anyone designated as the facility's Abuse Coordinator and verbalized the DON was responsible for reporting incidents and/or allegations of abuse, neglect and exploitation of residents to the State Agency (SA). Reportable incidents were those resulting in major injuries to a resident and any abuse. The DON explained the DON was ultimately responsible for investigating allegations and/or suspicion of abuse and neglect. An investigation would include talking to staff, talking to the resident/s, getting the provider involved and talking to the resident's family if needed to gather as many facts as possible.The DON confirmed the DON was familiar with Resident #10's fall in the dining room on 02/25/2026, as documented in the FRI. The DON explained the incident was different from other falls and was reported due to the ankle fracture identified in the x-ray. The investigation included speaking with the nurse on duty at the time of the fall and reviewing notes in the resident's clinical record. The DON denied the DON had documentation of the facility's investigation of the incident including any observations made and interviews conducted with residents and/or staff.The facility policy titled Freedom From Abuse/Abuse Prohibition, revised 01/19/2026, documented residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Neglect was defined as indifference or disregard for resident care, comfort or safety resulting in, or may have resulted in, physical harm, pain, mental anguish or emotional distress. When a direct care provider was suspected of abusing, neglecting or mistreating a resident the Chief Nursing Officer, Long-Term Care Supervisor, Chief Risk Officer, or the designated nursing supervisor could relieve the individual of his/her duty until the investigation was complete. Each situation would be assessed, and actions would be taken to prevent further potential abuse while the investigation was in progress.FRI 2791829

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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 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 care plan was developed with interventions to assist a resident to maintain continence after the previously continent resident began to experience occasional incontinence for 1 of 12 sampled residents (Resident #24). This deficient practice had the potential to result in staff not offering the resident services or assistance to maintain continence resulting in the resident experiencing worsening urinary incontinence.Findings include:Resident #24Resident #24 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including multiple sclerosis, unspecified and polyneuropathy, unspecified.On 04/20/2026 at 2:15 PM, the resident verbalized the resident had recently started experiencing occasional urinary incontinence but was still able to get to the bathroom once the resident realized they were urinating. The resident verbalized the resident could not recall any staff prompting the resident to go to the bathroom to urinate at timed intervals.A Minimum Data Set 3.0 (MDS) Assessment, dated 07/07/2025, documented the resident was always continent of bladder.An MDS Assessment, dated 04/06/2026, documented the resident was occasionally incontinent of bladder.The Care Plan for Resident #24 did not include a focused care area with interventions related to the resident's recent issue of urinary incontinence.On 04/22/2026 at 8:31 AM, the Director of Nursing (DON) verbalized the resident had become increasingly incontinent of urine over the last several months and the DON believed the incontinence was due to the resident's diagnosis of multiple sclerosis. The DON verbalized the facility could try to offer the resident assistance with a toileting schedule. The DON confirmed the resident's care plan did not include a care area or interventions related to the resident's concerns related to new onset urinary incontinence. The DON verbalized the facility did not have a policy for a bladder training or retraining program.A facility policy titled Resident Assessment Process, documented the purpose of developing a Care Plan was to establish a course of action (specific interventions) to be completed by staff knowledgeable about the resident's needs, develop care goals and approaches to carry out the how and when of resident care.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **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 previously continent resident received assistance or interventions to ensure the resident maintained or improved the resident's level of urinary continence when the resident began to experience occasional incontinence for 1 of 12 sampled residents (Resident #24). This deficient practice had the potential to result in a resident's incontinence worsening due to a lack of interventions or assistance to maintain or improve the resident's continence.Findings include:Resident #24Resident #24 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including multiple sclerosis, unspecified and polyneuropathy, unspecified.On 04/20/2026 at 2:15 PM, the resident verbalized the resident had recently started experiencing occasional urinary incontinence but was still able to get to the bathroom once the resident realized they were urinating. The resident verbalized the resident could not recall any staff prompting the resident to go to the bathroom to urinate at timed intervals.A Minimum Data Set 3.0 (MDS) Assessment, dated 07/07/2025, documented the resident was always continent of bladder.An MDS Assessment, dated 04/06/2026, documented the resident was occasionally incontinent of bladder.The Care Plan for Resident #24 did not include a focused care area with interventions related to the resident's recent issue of urinary incontinence.On 04/22/2026 at 8:24 AM, the Certified Nursing Assistant (CNA) for Resident #24 verbalized the resident had begun experiencing incontinence several months prior. The CNA verbalized the CNA was not aware of a bladder training or retraining program for the resident. The CNA verbalized an example of bladder training could include taking the resident to the bathroom at timed intervals, such as every two hours.On 04/22/2026 at 8:31 AM, the Director of Nursing (DON) verbalized the resident had become increasingly incontinent of urine over the last several months and the DON believed the incontinence was due to the resident's diagnosis of multiple sclerosis. The DON verbalized the facility could try to offer the resident assistance with a toileting schedule. The DON confirmed the resident's Care Plan did not include a care area or interventions related to the resident's concerns related to new onset urinary incontinence. The DON verbalized the facility did not have a policy for a bladder training or retraining program.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview, document review, and personnel record review, the facility failed to ensure a nurse aide performance review was completed at least once every 12 months and areas of weakness were identified and addressed for 1 of 2 sampled Certified Nursing Assistants (CNAs) employed at the facility greater than one year (Employee #8). This deficient practice had the potential to affect the care provided to all residents in the facility.Findings include:Employee #8Employee #8 was hired as a CNA on 10/21/2024.Employee #8's personnel record lacked documented evidence of a nurse aide performance evaluation.On 04/22/2026 at 1:55 PM, the Human Resources (HR) Director verbalized CNA performance evaluations were completed by the facility every year on October 1st to review the year prior. The HR Director explained because of the date of hire, Employee #8 was not reviewed for performance. The HR Director confirmed Employee #8's nurse aide performance review was not completed 12 months after starting at the facility.The Facility Assessment, updated 03/2026, documented areas of weakness as determined in nurse aide performance reviews and annual competency assessments would be addressed through in-service training.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and document review, the facility failed to ensure the Facility Assessment accurately reflected current staffing needs for the facility. This deficient practice had the potential to deprive residents of necessary care and services required to meet each individual's needs and preferences.Findings include:The Facility Assessment, updated 03/26/2026, documented the staffing plan included one licensed nurse on night shift for Harmony Manor and one licensed nurse on night shift for Quail Corner (memory care unit). Consistent staffing would be prioritized in the memory care unit. Staffing levels would not be adjusted for low census/low acuity so residents' needs would be met even in times of call in and other circumstances of staff shortages.The April 2026 staffing schedule documented Quail Corner and Harmony Manor would share a licensed nurse during night shift on 04/04, 04/05, 04/06, 04/07, 04/12, 04/13, 04/14, 04/18, 04/19, 04/20, and 04/26 of 2026.On 04/24/2026 at 9:27 AM, the Director of Nursing (DON) explained on Saturday, Sunday, Monday and Tuesday nights, both Quail Corner and Harmony Manor shared a licensed nurse during night shift. The DON explained on those days, the nurse would be responsible for all 32 residents in the facility. The DON confirmed the Facility Assessment indicated Quail Corner and Harmony Manor required a licensed nurse in each unit during night shift. The DON explained the Facility Assessment needed to be updated to reflect the staff scheduling.

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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. Based on observation, staff interview, and document review, the facility failed to ensure the staff maintained sanitary floor drains. This deficient practice had the potential to result in development and transmission of infection.Findings include:On 04/20/2026 at approximately 10:45AM a kitchen floor drain was observed to have a buildup of debris and grime. On 04/20/2026 at approximately 10:50 AM, the Kitchen Manager confirmed the kitchen floor drain had buildup of grime and acknowledged the potential spread of contamination. The Kitchen Manager explained the cleaning of the floor was the responsibility of the Maintenance Department.On 04/23/2026 at approximately 9:15 AM, the Maintenance Manager confirmed the kitchen floor drain had not been recently cleaned, was not sanitary and acknowledged the potential spread of contamination.The facility's policy titled, Maintenance of Strict Sanitary Conditions, dated 07/12/2022 and reviewed 07/08/2024, documented maintenance of strict sanitary conditions was of paramount importance in the Dietary and Nutrition Departments to eliminate food contamination and prevent growth of disease producing organisms, to ensure maximum level of cleanliness and sanitation in the department.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 a resident with a progressive, neurodegenerative disease was screened for a pneumococcal (PNA) vaccine for 1 of 5 residents reviewed for vaccine compliance (Resident #32). This deficient practice had the potential to result in a resident with a chronic illness not receiving a vaccine with the potential to prevent the resident from developing a severe illness leading to increased disability or death. Findings include: Resident #32 Resident #32 was admitted to the facility on [DATE], with diagnoses including Hallervorden-[NAME] Disease (a rare, inherited, and progressive neurodegenerative disorder) and other specified extrapyramidal and movement disorders. The clinical record for Resident #32 lacked documentation the resident had received or been offered a PNA vaccine. On 04/21/2026 at 3:27 PM, the Infection Preventionist (IP) verbalized the resident had not been screened to determine whether the resident wanted to receive a PNA vaccine because of the resident's young age. The IP confirmed the resident had a chronic, degenerative condition causing the resident to have trouble with swallowing placing the resident at an increased risk for PNA. On 04/21/2026 at 4:14 PM, the IP verbalized the IP had discussed offering the resident a PNA vaccine with the facility's Medical Director and the Medical Director had informed the IP the resident should have been offered a PNA vaccine. The facility policy titled Standing Orders for Administering Vaccines at Humboldt General Hospital, revised 01/01/2026, documented all residents admitted to the facility would be screened to determine whether they were current on adult immunizations. Pneumococcal immunization of all residents would be determined on admission. If the resident was not sure of their status, the attending physician would be contacted for an assessment before receiving the immunization.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on interview, personnel record review, and document review, the facility failed to ensure elder abuse prevention training was completed timely for 2 of 18 sampled employees (Employee #16 and #17). This deficient practice had the potential to place all residents at risk for abuse and neglect.Findings include:Employee #16Employee #16 was hired as a Cook, with a start date of 11/19/2025.Employee #16's personnel record documented elder abuse prevention training completed on 11/28/2025, 9 days late.Employee #17Employee #17 was hired as a Dietary Aide, with a start date of 12/15/2025.Employee #17's personnel record documented elder abuse prevention training completed on 12/31/2025, 16 days late.On 04/22/2026 at 1:45 PM, the Human Resources (HR) Director verbalized all staff were required to take initial elder abuse prevention training upon hire. The HR Director confirmed Employees #16 and #17 completed initial elder abuse prevention training late.The facility policy titled, Freedom from Abuse/Abuse Prohibition, revised 01/19/2026, documented employees would receive orientation upon hire to include training on abuse prohibition practices such as appropriate interventions, reporting, signs of burnout, frustration and stress, and what constitutes abuse, neglect and misappropriation of resident property.

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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 interview, personnel record review, and document review, the facility failed to ensure annual behavioral health care training was completed for 1 of 18 sampled employees (Employee #7). This deficient practice had the potential to prevent residents with behavioral health care needs from attaining or maintaining their highest practicable physical, mental and psychosocial well-being.Findings include:Employee #7Employee #7 was hired as a Certified Nursing Assistant (CNA) on 06/17/2019.Employee #7's personnel record documented annual behavioral health care training completed on 04/11/2025, however lacked documented evidence of behavioral health care training completed in 2026.On 04/22/2026 at 1:45 PM, the Human Resources (HR) Director verbalized dementia care training (behavioral health care training) was to be completed annually for all staff on or before the date of last completion. The HR Director verbalized Employee #7 was assigned behavioral health care training for 2026; however, Employee #7 had not yet completed the assigned training. The HR Director confirmed Employee #7 did work in the memory care unit of the facility and did have contact with residents diagnosed with dementia and Alzheimer's disease.The facility policy titled, Requirements for Staff Training in Alzheimer and Dementia Care, reviewed 11/07/2025, documented all staff employed by the facility with direct contact with resident with dementia must complete continuing education related to dementia for every year after the first year of employment.The Facility Assessment, updated 03/2026, documented staff would receive ongoing annual training in dementia care.