STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295029	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Pine Care Center	1500 Avenue G Ely, NV 89301

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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 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** 39418 Based on interview, record review and document review the facility failed to ensure consent for psychotropic medications were obtained for psychotropic medications for 2 of 12 sampled Residents (Resident 37 and 38). The deficient practice had the potential for resident or resident representatives to be informed of the purpose and the possible side effects of medication affecting brain functions. Findings include: Resident 37 (R37) R37 was admitted on [DATE], with diagnoses including major depressive disorder (MDD) and restlessness with agitation. R37's physician's order documented the following psychoactive medications: Seroquel (an antipsychotic medication) 25 milligrams (mg) by mouth one time a day for agitation. Order date: 5/1/2025. Seroquel 50 mg by mouth at bedtime for agitation. Order date: 4/30/2025. Sertraline Hydrochloride (HCl) (an antidepressant medication) 100 mg by mouth one time a day for MDD. Order date: 1/4/2025. R37's medical record lacked documented evidence a consent was obtained prior to initiating the pharmacological intervention. Resident 38 (R38) R38 was admitted on [DATE], with diagnoses including adult failure to thrive and depression. R38's physician's order documented the following psychoactive medications: Duloxetine Hydrochloride (HCl) (an antidepressant medication) 30 milligrams (mg) by mouth at bedtime. Order date: 1/13/2025. Duloxetine HCl 30 mg by mouth two times a day for pain. Order Date: 2/25/2025. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Olanzapine (an antipsychotic medication) 5 MG by mouth at bedtime for Depression. Order Date: 1/12/2025. R38's medical record lacked documented evidence a consent was obtained prior to initiating the pharmacological intervention. On 05/07/25 at 9:15 AM, the interim Director of Nursing (DON) reviewed the medical records and confirmed the listed medications were psychotropic medications and consents were not in the medical records. The DON indicated psychotropic medications consent should be filed in the medical records upon obtaining. The DON acknowledged consents for psychoactive medications were important to ensure disclosure of the effects of the medications and the possible side effects were discussed with the residents or their representatives. The facility policy titled Use of Psychotropic Medications (undated), documented prior to initiating or increasing a psychotropic medication, the resident, family, and/or representative must be informed of the benefits, risks, and the alternatives for the medication, including black box warnings for antipsychotic medications, in advance of such initiation or increase.

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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 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** 39418 Based on interview, record review and document review the facility failed to ensure 1) monitoring of psychotropic medications were documented in the medical record for 2 of 12 sampled Residents (Resident 9 and 20), and 2) psychotropic side effect monitoring orders were obtained for 3 of 12 sampled Residents (Resident 36, 37, and 38). The deficient practice had a potential for residents not to be monitored for early signs of side effects caused by psychoactive medications. Findings include: 1) Resident 9 (R9) R9 was admitted on [DATE], with diagnoses including Major Depressive Disorder (MDD) and schizoaffective disorder. R9's physician's order documented the following psychoactive medications: Aripiprazole (an antipsychotic medication) 2.5 milligrams (mg) by mouth one time a day related to MDD. Order Date: 01/25/2024. Duloxetine Hydrochloride (an antidepressant medication) 60 mg by mouth at bedtime related to MDD. Order date: 09/03/2024. Both Aripiprazole and Cymbalta had a black box warning (the most severe warning the Food Drug Administration - FDA places on a medication's label) specifying: Increased risk of suicide in adults. High risk of major depressive or other psychiatric disorders (mania, hallucinations). Resulted in numerous Birth defect. R9's physician's order dated 09/28/2024, documented Administration Note: Increased risk of suicide in adults. High risk of major depression or other psychiatric disorders (mania, hallucinations). Resulted in numerous Birth defect. Monitor every day and night shift. The order was transcribed onto the Medication Administration Record (MAR). Review of the nurse entries on the MAR revealed numerous encodings of #9 followed by the nurse initials, (MAR numerical legend indicated #9 as, other/ see progress notes). There was a lack of documented entries in the progress notes to indicate what was observed from the numerical entry of #9 from the nurse. Resident 20 (R20) R20 was admitted on [DATE], with diagnoses including hallucinations and insomnia due to other mental disorders. R20's physician's order documented the following psychoactive medications: (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Seroquel (an antipsychotic medication) 37.5 mg by mouth at bedtime for Prophylaxis. Order date 04/08/2025. Sertraline (an antidepressant medication) 25 mg by mouth one time a day for dementia with depressed mood. Order date: 06/04/2024. Trazodone (an antidepressant medication) 50 mg by mouth in the evening for Depression causing insomnia. Order date: 07/10/2024. Both Sertraline and Trazodone had a black Box Warning. Indicating: Suicidality and antidepressant drugs. Antidepressants increased the risk of suicidal thoughts and behavior in adult patients in short-term studies. Closely monitor all antidepressant-treated patients for clinical worsening, and for emergence of suicidal thoughts and behaviors. R20's physician's orders documented the following order: 09/28/2024, documented monitor for increased risk of suicide in adults. High risk of major depression or other psychiatric disorders (mania, hallucinations). Resulted in numerous Birth defect. Monitor every day and night shift 06/03/2024, Behaviors - Monitor for the following: hallucinations, two times a day. Review of April and May 2025, MAR revealed inconsistent monitoring of R20 wherein dates and shifts were not signed to attest monitoring of the behavior was completed. On 05/07/2025 at 9:15 AM, the Director of Nursing (DON) reviewed R9 and R20's MAR and progress notes. The DON confirmed entries of #9 on the MAR should be accompanied with a notation of the nurse in the progress notes. The DON indicated R20's MAR should be signed off every shift to verify the resident was monitored for the side effects of the psychotropic medication. 2) Resident 36 (R36) R36 was admitted on [DATE], with diagnoses including bipolar disorder and depression. R36's physician's order documented the following psychoactive medications: Bupropion (an antidepressant medication) 150 mg by mouth one time a day. Order date: 12/7/2024. Duloxetine Hydrochloride (and antidepressant medication) 60 mg by mouth one time a day. Order date: 12/7/2024. Clonazepam (a benzodiazepine sedative) 1 mg by mouth two times a day. Order date: 1/27/2025. Resident 37 (R37) R37 was admitted on [DATE], with diagnoses including major depressive disorder (MDD) and restlessness with agitation. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R37's physician's order documented the following psychoactive medications: Seroquel (an antipsychotic medication) 25 mg by mouth one time a day for agitation. Order date: 5/1/2025. Seroquel (an antipsychotic medication) Oral 50 mg by mouth at bedtime for agitation. Order date: 4/30/2025. Sertraline (an antidepressant medication) 100 mg by mouth one time a day for MDD. Order date: 1/4/2025. Resident 38 (R38) R38 was admitted on [DATE], with diagnoses including adult failure to thrive and depression. R38's physician's order documented the following psychoactive medications: Duloxetine Hydrochloride (and antidepressant medication) 30 mg by mouth at bedtime. Order date: 1/13/2025 Duloxetine Hydrochloride (and antidepressant medication) 30 mg by mouth two times a day for pain. Order Date: 2/25/2025 Olanzapine (an antipsychotic medication) 5 mg by mouth at bedtime for Depression. Order Date: 1/12/2025 20:00 R36, R37 and R38's physician's orders for psychotropic medications had a corresponding block box warning indication to monitor for side effects. R36. R37 and R38's lacked documented evidence physician's orders for side effect monitoring was entered. On 05/06/2025 at 1:55 PM, a Licensed Practical Nurse (LPN) indicated the nurse entering the medication order was responsible for ensuring side effect monitoring orders were entered in conjunction with psychotropic medications with block box warnings. The nurse agreed some of the residents with psychotropic medications did not have the side effect monitoring orders placed as a physician's orders. On 05/07/25 at 9:15 AM, the Director of Nursing (DON) reviewed the medical records and confirmed the medications were psychotropic medications with block box warnings. The DON confirmed R36, 37 and R38 did not have any orders to monitor the side effects of the medications. The DON acknowledged the importance of the early detection of the side effects of the drug. The facility policy titled Use of Psychotropic Medications (undated), documented the resident's response to the medication, including progress towards goals and presence and absence of adverse consequences, shall be documented in the resident's medical record.

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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** 39418 Based on interview, record review and document review, the facility failed to ensure timely reporting to the State Agency of an incident of abuse for 1 of 12 sampled Resident (Resident 30). The deficient practice had potential for an untimely review by the SA of the investigative process completed by the facility to ensure corrective actions were taken. Findings include: Resident 30 (R30) R30 was admitted on [DATE], with diagnoses including hypertension and chronic obstructive pulmonary disease. Resident 5 (R5) R5 was admitted on [DATE], with diagnoses including epilepsy and schizoaffective disorder. Review of R30's medical record documented an incident with R5. A summary of the incident is as follows: On 03/06/2025 at approximately 8:35 PM, R30 was having a conversation with one of the nurses. R5 walked over to the office to join the conversation and was standing in the doorway when R5 began to lean forward as if was going to fall. To regain balance, R5 reached out and placed hand on R30's left neck in the space between neck and shoulder. R30 put hand on R5's abdominal area to keep from falling. R5 then began to shout at R30 to not touch the resident. R5 repeated self three times. The nurse had already gotten out of the chair when two CNAs arrived at the office door to help and to redirect R5 back to the room. No restraint or force was needed or used. R30 stated having pain on the resident's left side from the weight of R5 trying to regain balance but declined further medical evaluation. R5 and R30's progress notes revealed no untoward effects of the incident. Review of the investigation packet completed by the facility revealed the facility had completed a thorough investigation of the incident. The compiled staff statements revealed R30 continuously alleged R5 of physical abuse after the incident. The report documented the Administrator in Training (AIT) was made aware of the incident on 03/07/2025 at 1:00 PM. The Facility Reported Incident was filed initially to the SA on 03/12/2025, and a final report on 03/14/2025. On 05/06/2025 at 2:50 PM, the AIT confirmed the reporting was delayed to the SA and the incident should have been reported within the 24-hour period. The AIT acknowledged the importance of reporting abuse to the SA and compliance with the regulations. (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 policy titled Abuse, Neglect and Exploitation (undated), documented reporting all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified time frames: Not later than 24 hours if the event that caused do not involve abuse and do not result in serious bodily injury.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 39418 Based on observation, interview, record review and document review, the facility failed to ensure comprehensive care plans were created for 1) contractures and its management for 2 of 12 sampled residents (Resident 9 and 10) and 2) use of psychotropic medications with its corresponding indications and diagnoses for 5 of 12 sampled residents (Resident 9, 20, 36, 37 and 38). The deficient practice had potential for residents not to have care that is person centered pertaining to their diagnoses, medications, monitoring and care needs. Findings include: 1) Resident 9 (R9) R9 was admitted on [DATE], with diagnoses including hemiparesis following cerebral infarction and muscle weakness. R9 was observed on 05/05/2025 at 10:36 AM, wearing a right arm splint and deformity of the right lower extremity with right foot pointing inward and slight drop. R9 indicated staff applies the right arm splint. R9 physician's order dated 02/05/2025: Occupational Therapy (OT) clarification: Resident to participate in skilled OT services three times a week for 4 weeks. R9's OT Discharge Summary dated 02/26/2025, documented under Discharge Recommendations and Status: Functional Maintenance - Splint and Brace program established/trained: Wear schedule for right hand orthotic. R9's comprehensive care plan lacked documented evidence in addressing R9's contractures and use of splints. On 05/05/2025 at 3:12 PM, the consultant director of nursing (DON) confirmed R9 wears a right arm splint and indicated the importance of having a comprehensive care plan in addressing the application of the splint and also the care and maintenance needed for a resident wearing a splint. Resident 10 (R10) R10 was admitted on [DATE], with diagnoses including spastic hemiplegic cerebral palsy and scoliosis. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/04/2024 at 2:45 PM and 05/05/2025 at 10:10 AM, R10 was observed mobilizing self in a wheelchair. R10 was noted to have right arm pulled to upper chest and with wrist and hand curling. There was no support to the arm and hands preventing the involuntary flexion (a bending movement around a joint in a limb that decreases the angle between the bones of the limb at the joint of the muscles) of the right upper extremity. R10's Comprehensive Care Plan dated 10/24/2024 at 10:49 AM, documented R10 has limited physical mobility related to spastic hemiplegic cerebral palsy and multiple previous fractures. R10 will remain free of complications related to immobility, including contractures, thrombus formation, skin-breakdown, fall related injury through the next review date. Monitor/document/report as needed signs and symptoms of immobility: contractures forming or worsening, thrombus formation, skin-breakdown, fall related injury. R10's current comprehensive care plan lacked documented evidence of any interventions to prevent and improve limitations of ROM and any interventions to prevent contractures. On 05/05/2025 at 3:12 PM, the DON confirmed had observed R10's right arm and hand contractures. The DON reviewed R10's medical record and confirmed R10's lack of care plan interventions. The consultant indicated care plan interventions for contractures could be as simple as nursing practices and be part of nursing assessments and interventions which should have been put into place to prevent progression of contractures. 2) Resident 9 (R9) R9 was admitted on [DATE], with diagnoses including major depressive disorder (MDD) and schizoaffective disorder. R9's physician's order documented two active psychotropic medications. Resident 20 (R20) R20 was admitted on [DATE], with diagnoses including hallucinations and insomnia due to other mental disorders. R20's physician's order documented three active psychotropic medications: Resident 36 (R36) R36 was admitted on [DATE], with diagnoses including bipolar disorder and depression. R36's physician's order documented three active psychotropic medications. Resident 37 (R37) R37 was admitted on [DATE], with diagnoses including major depressive disorder (MDD) and restlessness with agitation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R37's physician's order documented three active psychotropic medications. Resident 38 (R38) R38 was admitted on [DATE], with diagnoses including adult failure to thrive and depression. R37's physician's order documented two active psychotropic medications. R9, R20, R36, R37 and R38 lacked a comprehensive care plan addressing the residents' diagnoses and the psychotropic medications the residents are receiving. On 05/06/2025 at 1:55 PM, the Licensed Practical Nurse (LPN) indicated the nurse entering the medication order was responsible for ensuring side effect monitoring orders were entered in conjunction with psychotropic medications with black box warnings. The nurse indicated the DON in conjunction with MDS was responsible for entering care plans for the residents. On 05/07/25 at 9:15 AM, the Director of Nursing (DON) reviewed the medical records and confirmed the lack of care plans pertaining to the resident's diagnoses. The DON agreed psychiatric diagnoses and psychotropic medications should be carefully care planned due to the numerous interventions that had be covered in terms of behavioral interventions, care approaches and the management of psychotropic medications. The facility policy titled Use of Psychotropic Medications (undated), documented the effects of psychotropic medications on a resident's physical, mental, and psychological well-being will be evaluated on an ongoing basis, such as: In accordance with nurse assessments and medication monitoring parameters consistent with clinical standards of practice and the resident's comprehensive plan of care. The facility policy titled Comprehensive Care Plan (Undated), documented the facility is to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objective and time frames to meet a resident's medical, nursing and mental and psychological needs and ALL services that are identified in the resident comprehensive assessment and meet professional standards of care.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39418 Based on observation, interview, record review and document review, the facility failed to ensure 1) a neurological check after a head injury was completed for 1 of 12 sampled Residents (Resident 14). The deficient practice had potential for a resident not to be monitored for latent effects of a head injury and 2) splinting orders were obtained for 1 of 12 sampled Resident (Resident 9). The deficient practice had potential for not receiving continuity of care with prevention of contractures. Findings include: 1) Resident 14 (R14) R14 was admitted on [DATE], with diagnoses including Parkinson's disease and muscle weakness. R14's progress notes documented the following incident: On 04/08/2025 at 2:20 PM, Incident Note: Member of housekeeping alerted Nursing Staff about R14 falling after standing from wheelchair in front of nightstand. R14 fell and hit the right ear lobe and began bleeding. R14 is also on a blood thinner which could have increased the bleeding. R14 was helped back into the wheelchair by the staff. Nursing had bandaged the ear after hearing aid was removed. R14 was transported via facility van to the Emergency Department (ED) with two certified nursing aides. R14 was returned to the facility the same day after treatment and evaluation from the ED. A physician's visit note dated 04/09/2025 at 9:25 AM, documented ground-level fall on 04/08/2025 due to slippers around 2:00 PM, unwitnessed, sustained right ear laceration status post suture placement in emergency room , questionable head injury and loss of consciousness. Physical exam with right ear laceration with suture, no bleeding. Slow on cerebellar function with finger-to-nose test and alternate hand turning. Start neuro check for 3 days and head computerized tomography scan (CT). Continue trending vital signs 3 times daily for 1 week. Suture to be removed in 10 days. R14's medical records lacked documented evidence, a post fall assessment and neurological checks were completed after a fall causing a head injury. On 05/07/2025 at 9:28 AM, the interim director of nursing (DON) indicated remembering the incident. The DON reviewed R14's medical record and confirmed the absence of fall assessment and neurological checks. The DON acknowledged neuro checks should have been initiated after the fall and continued even with a negative CT of the head, to ensure the resident is monitored for any latent effects of a head injury. The facility policy titled Head Injury (Undated), documented 1) assess resident following a known, suspected, or verbalized head injury. 4) perform neuro checks as indicated or as specified by the physician. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Resident 9 (R9) R9 was admitted on [DATE], with diagnoses including hemiparesis following cerebral infarction and muscle weakness. R9 was observed on 05/05/2025 at 10:36 AM, wearing a right arm splint and deformity of the right lower extremity with right foot pointing inward and slight drop. R9 indicated staff applies the right arm splint. R9's physician's order dated 02/05/2025: Occupational Therapy (OT) clarification: Resident to participate in skilled OT services three times a week for 4 weeks for diagnosis: hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, muscle weakness, flaccid hemiplegia affecting right dominant side. Plan of Care (POC) to include the following: orthotic management and training, therapeutic activity, self-care training, therapeutic exercises, neuromuscular re-education. No directions specified for order. R9's OT Discharge Summary dated 02/26/2025, documented under Discharge Recommendations and Status: Functional Maintenance - Splint and Brace program established/trained: wear schedule for right hand orthotic. R9's medical record lacked physician order for the application and care/maintenance of the right-hand splint. On 05/05/2025 at 2:47 PM, the Occupational Therapist Assistant (OTA) indicated R9 has been diligent in requesting right arm splint to be applied by staff. The OTA confirmed there was no set schedule for the splint to be applied. The OTA agreed physician orders should have been placed to ensure staff would apply the splint according to specific orders. On 05/05/2025 at 3:12 PM, the Director of Nursing (DON) confirmed R9 wears a right arm splint and indicated the importance of having a physician's order to ensure implementation of splint care. The DON acknowledged nursing would take therapy discharge recommendations and implement it as a physician's order then transcribe the order onto the treatment administration record. The process ensures staff would be triggered to apply the splint and ensures continuity of care. The facility policy titled Provisions of Physician's Orders (undated), documented qualified nursing personnel will submit timely requests for physician ordered services from the appropriate entity. This policy is to provide reliable processes for the proper and consistent provision of physician ordered services according to professional standards of care.

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39418 Based on observation, interview, record review and document review, the facility failed to ensure a resident was assessed and interventions were implemented for upper extremity contractures for 1 of 12 sampled Residents (Resident 10). The deficient had potential for a resident not to maintain mobility and prevent the progression of contractures. Findings include: Resident 10 (R10) R10 was admitted on [DATE], with diagnoses including spastic hemiplegic cerebral palsy and scoliosis. On 05/04/2024 at 2:45 PM and 05/05/2025 at 10:10 AM, R10 was observed mobilizing self in a wheelchair. R10 was noted to have right arm pulled to upper chest and with wrist and hand curling. There was no support to the arm and hands preventing the involuntary flexion (a bending movement around a joint in a limb that decreases the angle between the bones of the limb at the joint of the muscles) of the right upper extremity. R10's last Occupational Therapy (OT) Discharge Summary dated 05/22/2023, documented R10 was able to raise arms straight out from shoulders. The prognosis is to maintain the current level of function was good with consistent staff follow-through. R10's Progress Notes documented the following assessments: 04/22/2024 at 9:27 PM, Note Text: This writer completed MDS interviews/assessments for R10. R10 had a right arm contracture. R10's Comprehensive Care Plan dated 10/24/2024 at 10:49 AM, documented R10 has limited physical mobility related to spastic hemiplegic cerebral palsy and multiple previous fractures. R10 will remain free of complications related to immobility, including contractures, thrombus formation, skin-breakdown, fall related injury through the next review date. Monitor/document/report as needed signs and symptoms of immobility: contractures forming or worsening, thrombus formation, skin-breakdown, fall related injury. R10's medical record lacked documented evidence of any current involvement of rehabilitative services, physicians' orders to prevent and improve limitations of ROM and care plan interventions to prevent contractures. On 05/05/2025 at 3:12 PM, the Director of Nursing (DON) confirmed had observed R10's right arm and hand contractures. The DON reviewed R10's medical record and confirmed R10's lack of care plan interventions and orders to have rehabilitative services to assess R10's progression of right arm contracture from the last OT services. The DON indicated early detection of contractures should be part of nursing assessments and interventions should have been put into place to prevent progression. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295029	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Pine Care Center	1500 Avenue G Ely, NV 89301

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Conducting an Accurate Assessment (undated), documented the physical, mental and psychological condition of the resident determines the appropriate level of involvement of physicians, nurses, rehabilitation services, activities, social workers, dieticians and other professionals in assessing the residents and in correcting resident assessments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295029	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Pine Care Center	1500 Avenue G Ely, NV 89301

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39418 Based on observation, interviews, record review and document review, the facility failed to ensure Oxygen (O2) saturations (a measure of how much oxygen a person's blood is carrying, expressed as a percentage) were obtained as ordered for the titration of O2 for 2 of 12 sampled residents (Resident 4 and 36). The deficient practice had potential for a resident to receive more O2 than what the body requires. Resident 4 (R4) R4 was admitted on [DATE], with diagnoses including chronic kidney disease and hypertension. On 05/04/2025 at 3:45 PM, R4 was observed sitting by the bedside with an oxygen cannula. The resident's concentrator (a medical device that separates oxygen from air, providing a higher concentration of oxygen to individuals who need supplemental oxygen therapy) was set to deliver 4 liters of Oxygen. R4 shrugged shoulders when asked who adjusts the level of the Oxygen machine. R4 physician's order dated 10/12/2024, documented Oxygen: (2 to 4) Liters per minute, Delivery: Cannula or mask to keep Oxygen saturation (O2 sats) greater than 90%, every shift for low O2 sats. R4's April and May Medication Administration Record (MAR) revealed inconsistent documentation of obtaining the resident's O2 saturations. Resident 36 (R36) R36 was admitted on [DATE], with diagnoses including chronic ischemic heart disease and peripheral vascular diseases On 05/05/2025 at 8:47 AM, R36 was observed with the O2 concentrator set at 5 liters via nasal cannula. R5 indicated nurses were the ones adjusting the level of O2. R36 physician's order lacked any specific O2 liters to be delivered. A physician's order dated 12/07/2024, documented O2 saturation every shift. R36's April and May Medication Administration Record (MAR) revealed inconsistent documentation of obtaining the resident's O2 saturations. On 05/05/25 at 3:20 PM, the Director of Nursing (DON) reviewed R4 and R5's MAR and confirmed the inconsistent documentation of the resident's O2 saturations. The DON acknowledged the importance of monitoring O2 saturations and adjusting the O2 liters to the least possible amount while maintaining adequate oxygenation. The facility policy titled Oxygen Administration (undated), documented monitoring O2 saturation levels and/or vital signs as ordered by the physician.