STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295043	A. Building B. Wing	12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpine Skilled Nursing and Rehabilitation Center	3101 Plumas St Reno, NV 89509

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on observation, interview, clinical record review, and document review the facility failed to administer medications per a physician's order for 2 of 7 sampled residents (Resident #2 and #3). Findings include: Resident #2 Resident #2 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including vitamin D deficiency, unspecified and mild protein-calorie malnutrition. On 12/21/23 at 8:53 AM, a Licensed Practical Nurse (LPN) began preparing medications for Resident #2. One of the medications prepared was one tablet of Calcium Citrate-Vitamin D 400 milligrams (mg)-12.5 micrograms (mcg). On 12/21/23 at 8:56 AM, the LPN administered the prepared medications to Resident #2. An Order Review History Report for Resident #2 documented the following: -Calcium Citrate-Vitamin D oral tablet chewable 500-10 mg-mcg. Give one tablet by mouth one time a day for supplement. On 12/21/23 at 1:39 PM, the LPN reviewed Resident #2's medication orders and confirmed the resident's order was for Calcium Citrate-Vitamin D 500 mg-10 mcg. The LPN confirmed the Calcium Citrate-Vitamin D tablet administered to Resident #2 was 400 mg-12.5 mcg and did not match the physician's order. Resident #3 Resident #3 was admitted to the facility on [DATE], with a diagnosis of pain, unspecified. On 12/21/23 at 8:59 AM, an LPN began preparing medications for Resident #3. One of the medications prepared was one Salonpas Lidocaine 4 percent (%) patch. On 12/21/23 at 9:08 AM, the LPN administered the prepared medications to Resident #3. The Lidocaine patch was applied to the resident's right shoulder. (continued on next page)

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
	295043	A. Building B. Wing	12/21/2023

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Order Review History Report for Resident #3 documented the following: -Lidocaine patch 4%, apply to left shoulder topically in the morning for left shoulder pain. Remove patch after 12 hours. On 12/21/23 at 1:39 PM, the LPN confirmed the Lidocaine patch was applied to Resident #3's right shoulder. The LPN reviewed Resident #3's medication orders and confirmed the order was to apply the Lidocaine patch to the resident's left shoulder. The LPN verbalized the LPN should have verified the order prior to administering the patch and should have contacted the physician to obtain a new order to place the patch on the right shoulder. On 12/21/23 at 1:20 PM, during an interview with the Director of Nursing (DON) and the Administrator, the DON and the Administrator confirmed applying the lidocaine patch to a location different than indicated on a physician's order or administering the wrong dose of a medication was not following a physician's order. The facility policy titled Verbal Orders, revised 09/2017, documented the facility would comply with related laws and regulations. The facility policy titled Liberalized Medication Administration - Policy and Procedure, created 02/2023, documented the general nursing standard of practice for medication administration would remain in place. Nevada Nurse Practice Act NAC 632.236 (NRS 632.120), revised 08/2019, documents before carrying out an order, a licensed practical nurse must: understand the order, verify the order is appropriate, and verify there are no documented contraindications in carrying out the order. Nevada Nurse Practice Act NAC 632.238 (NRS 632.120), revised 08/2019, documents a licensed practical nurse may prepare the required dosage of a medication and administer medication.