

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295043	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Alpine Skilled Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50210</p> <p>Based on interview, clinical record review, and document review, the facility failed to ensure a resident was protected from verbal and physical abuse by a Certified Nursing Aide (CNA) when the CNA yelled at and threw an object at 1 of 5 sampled residents (Resident #1). This deficient practice had the potential to result in physical and psychosocial harm.</p> <p>Findings include:</p> <p>Resident #1</p> <p>Resident #1 was admitted to the facility on [DATE], and readmitted on [DATE], with a primary diagnosis of chronic hepatic failure without coma.</p> <p>A Resident Abuse Interview with Resident #1 dated 05/07/2024, documented the CNA was rude to Resident #1 when the CNA yelled at the resident, threw a pillow at the resident and shoved a pillow under the resident. Resident #1 was afraid to ask for help because of the way the resident was treated.</p> <p>A witness statement from Resident #1 dated 05/07/2024, documented the resident asked the CNA to assist with cleaning after a bowel movement but the CNA yelled at the resident don't tell me how to do my job. After the argument, Resident #1 asked the CNA for a pillow and the CNA threw the pillow at the resident. Later in the shift, the CNA returned to the resident and shoved a pillow under the resident's back. Resident #1 verbalized being uncomfortable and the CNA told the resident to stop micromanaging.</p> <p>A witness statement from Resident #1's roommate dated 05/07/2024, documented the roommate witnessed yelling between the CNA and Resident #1 and observed the CNA throw a pillow at Resident #1.</p> <p>Resident #1's care plan included a focus initiated 05/10/2024, documenting Resident #1 was at risk for emotional distress related to an incident with a staff member.</p> <p>A Complaint Form to the Nevada State Board of Nursing, dated 05/13/2024, documented a complaint against the CNA related to substantiated verbal, physical, and emotional abuse towards a resident.</p> <p>(continued on next page)</p>

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: 295043	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Alpine Skilled Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/05/2024 at 2:55 PM, the Director of Nursing/Abuse Coordinator verbalized abuse could be anything that made the resident feel uncomfortable or scared. The Abuse Coordinator explained the facility did report the CNA to the Nevada State Board of Nursing because the Abuse Coordinator substantiated the allegation for abuse. The Abuse Coordinator verbalized the CNA threw a pillow at Resident #1 and yelled at the resident.</p> <p>The CNA job description dated 01/2020, documented the CNA had a duty to treat residents with courtesy, respect, and dignity.</p> <p>The facility policy titled, Recognizing Signs and Symptoms and Abuse or Neglect, dated 01/2011, documented abuse was defined as willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.</p> <p>The facility policy titled, Abuse Prevention Program, dated 12/2016, documented administration would protect residents from abuse by anyone including facility staff.</p> <p>Complaint #NV00072523</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295043	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Alpine Skilled Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557</p> <p>Based on clinical record review, interview, and document review, the facility failed to ensure a resident with a stage four pressure ulcer was evaluated timely by the facility's Registered Dietician and a physician ordered nutritional supplement was administered to the resident (Resident #1). This deficient practice had the potential to result in a pressure ulcer to not receive the services and treatment to promote healing and prevention.</p> <p>Findings include:</p> <p>Resident #1</p> <p>Resident #1 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unspecified severe protein-calorie malnutrition and pressure ulcer of sacral region, stage four.</p> <p>A Physician Note dated 01/18/2024, documented Resident #1 had severe protein-calorie malnutrition and a stage four pressure ulcer of the sacral region. The plan included a dietary evaluation and Pro-Stat (a concentrated liquid protein drink).</p> <p>A Physician Order dated 01/22/2024, documented Pro-Stat, one drink per day with lunch. The order was created by the Physician and confirmed by a Registered Nurse (RN) on 01/22/2024.</p> <p>Resident #1's January 2024 Medication Administration Record (MAR) documented Pro-Stat, one drink per day with lunch. No administrations of Pro-Stat were documented on the January 2024 MAR.</p> <p>Resident #1's Care Plan included a focus of multiple pressure ulcers related to immobility and end stage liver disease. Interventions included:</p> <p>-Administer medications as ordered. The date initiated was 01/29/2024.</p> <p>-Assess nutritional status. The date initiated was 01/29/2024.</p> <p>A Nutrition/Dietary Note dated 03/19/2024, documented diet changed from no added salt to regular. Wounds to resident's sacrum and right hip, will add Pro-Stat daily to aid in wound healing and provide an additional 15 grams (g) of protein per day.</p> <p>Resident #1's clinical record lacked documented evidence a dietary evaluation was completed in January or February 2024.</p> <p>On 12/05/2024 at 3:00 PM, during an interview with the Director of Nursing (DON) and the Administrator, the DON verbalized the facility's Registered Dietician (RD) or the RD's assistant would evaluate all residents upon admission to the facility. The intent of the dietary evaluation was to make sure the facility was addressing all the nutritional needs of each resident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295043	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Alpine Skilled Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON and Administrator reviewed Resident #1's clinical record and confirmed the Physician note dated 01/18/2024, documented a plan of dietary evaluation and Pro-Stat for severe protein-calorie malnutrition. The DON and Administrator confirmed Resident #1's clinical record lacked documented evidence a dietary evaluation was completed timely, upon admission to the facility.</p> <p>The DON confirmed a physician order dated 01/22/2024, documented Resident #1 was prescribed Pro-Stat once daily with lunch. The DON confirmed the order was signed by the physician and had been confirmed by an RN. The DON explained when an order was confirmed by a nurse it equated to the nurse acknowledging the order. The DON explained Pro-Stat was ordered for residents who may not be getting enough protein in the resident's diet or to help with wound healing.</p> <p>The DON and Administrator explained Pro-Stat would not have been delivered by dietary staff and would have been administered by nursing staff. The DON reviewed Resident #1's January 2024 MAR and confirmed the MAR lacked documentation of any administrations of Pro-Stat.</p> <p>The facility policy titled Food and Nutrition Services, adopted by the facility on 02/01/2019 and reviewed annually, documented the multidisciplinary staff would assess each resident's nutritional needs.</p> <p>The facility policy titled Nutrition Risk - Weight Loss Management Policy and Program, undated, documented the program emphasized assessment, identification and intervention to promote resident nutrition. The criteria for immediate referral to the Food Services Department and/or Registered Dietician (RD) and care plan interventions within 72 hours of admission included stage two, three, or four pressure ulcers. Food Services Department or RD would complete a Comprehensive Nutrition and Hydration Assessment which included a progress note titled Nutrition/Dietary Note.</p> <p>The facility policy titled Skin and Wound Management, last revised 01/11/2024, documented residents with stage two or greater pressure ulcers would be referred to the RD. The RD would assess for nutritional interventions and develop a plan as indicated.</p> <p>Complaint #NV00072523</p>		