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	06/11/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review, the facility failed to protect a resident's right to a dignified existence without discrimination when a resident-to-resident verbal altercation involved the use of racial slurs for 1 of 11 sampled residents (Resident #11). This deficient practice had the potential to result in psychosocial harm. Findings include: Resident #10 Resident #10 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of bipolar disorder, unspecified. Resident #10's care plan included a focus initiated on 12/05/2024, documenting Resident #10 demonstrated a potential for verbally aggressive behaviors as evidenced by yelling out related to a cognitive communication deficit and bipolar disorder. A nursing narrative note, dated 05/28/2025, documented Resident #10 walked past another resident's room. The other resident was on the phone and yelled at Resident #10 to get away. Resident #10 yelled out a racial slur. The Nurse spoke with the other resident who confirmed the incident and verbalized doing their best to stay away from Resident #10, but Resident #10 kept coming back. The residents had a history involving the police. A communication note dated 05/29/2025, documented the Licensed Master Social Worker met with Resident #10 regarding the resident-to-resident interaction the previous day. They discussed the resident's ability to distance themselves from other people the resident may have a negative interaction with. Resident #11 Resident #11 was admitted to the facility on [DATE], with diagnoses including cognitive communication deficit and anxiety disorder, unspecified. Resident #11's care plan with a focus initiated on 04/28/2024, and last revised on 04/03/2025, documented Resident #11 was at risk for adverse consequences of post-traumatic stress disorder related to a history of abuse and racial trauma. The care plan was not updated after the 05/28/2025 incident. (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: 295043	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2025

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A communication note dated 05/29/2025, documented the Licensed Master Social Worker met with Resident #11 regarding the resident-to-resident interaction the previous day. They discussed the resident's ability to distance themselves from other people the resident may have a negative interaction with. Resident #11's clinical record lacked any other documentation related to the incident occurring on 05/28/2025. On 06/11/2025 at 1:59 PM, Resident #10 verbalized a few weeks prior, Resident #11 approached Resident #10 and called Resident #10 derogatory names. Resident #10 yelled racial slurs in return. On 06/11/2025 at 2:05 PM, Resident #11 verbalized Resident #10 walked by Resident #11's room, stopped in the doorway and used racial profanity. The facility then asked Resident #11 to move rooms and requested the residents stay away from one-another. On 06/11/2025 at 3:34 PM, a Certified Nursing Assistant (CNA) explained staff could view resident care plans to ascertain if resident needs changed and what actions staff were expected to take. The CNA explained Resident #10 had a history of yelling profanity. The CNA was unaware of any altercation between Residents #10 and #11. On 06/11/2025 at 3:43 PM, a Licensed Practical Nurse (LPN) verbalized two weeks prior Resident #11 was on the phone in the resident's room. Resident #10 stopped in Resident #11's doorway and used racial slurs toward Resident #11. The LPN explained the LPN was at the end of another hallway, heard the altercation, and was able to get to the residents quickly. Since the incident, Resident #11 began avoiding Resident #10. On 06/11/2025 at 6:32 PM, the Abuse Coordinator/Director of Nursing AC/DON confirmed the incident and verbalized using racial slurs would be considered racially abusive language, bullying and harassment. The AC/DON confirmed racism was a pervasive issue in the facility and verbalized in healthcare, racially discriminatory behavior was normalized. The AC/DON explained the facility could have offered talk therapy, reached out to Behavioral Health Services for additional interventions, and implemented care plans related to racial discrimination. The facility policy, titled Non-Discrimination, adopted 02/01/2019, documented the facility did not permit discrimination, bullying, abuse, or harassment on the basis of actual or perceived race. Discrimination of any form, including ethnic slurs would be promptly reported to the Administrator. The facility policy, titled Resident Rights, adopted 02/01/2019, documented residents had the right to be treated with respect and dignity. Cross reference with F610 and F657.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review, the facility failed to ensure an allegation of verbal abuse was investigated and reported to the State Agency (SA) for 1 of 11 sampled residents (Resident #11). This deficient practice had the potential to result in psychosocial harm due to allegations of abuse not being thoroughly investigated and protections not put in place to prevent future abuse. Findings include: Resident #10 Resident #10 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of bipolar disorder, unspecified. Resident #10's care plan included a focus initiated on 12/05/2024, documenting Resident #10 demonstrated a potential for verbally aggressive behaviors as evidenced by yelling out related to a cognitive communication deficit and bipolar disorder. A nursing narrative note, dated 05/28/2025, documented Resident #10 walked past another resident's room. The other resident was on the phone and yelled at Resident #10 to get away. Resident #10 yelled out a racial slur. The Nurse spoke with the other resident who confirmed the incident and verbalized doing their best to stay away from Resident #10, but Resident #10 kept coming back. The residents had a history involving the police. A communication note dated 05/29/2025, documented the Licensed Master Social Worker met with Resident #10 regarding the resident-to-resident interaction the previous day. They discussed the resident's ability to distance themselves from other people the resident may have a negative interaction with. Resident #11 Resident #11 was admitted to the facility on [DATE], with diagnoses including cognitive communication deficit and anxiety disorder, unspecified. Resident #11's care plan with a focus initiated on 04/28/2024, and last revised on 04/03/2025, documented Resident #11 was at risk for adverse consequences of post-traumatic stress disorder related to a history of abuse and racial trauma. The care plan was not updated after the 05/28/2025 incident. A communication note dated 05/29/2025, documented the Licensed Master Social Worker met with Resident #11 regarding the resident-to-resident interaction the previous day. They discussed the resident's ability to distance themselves from other people the resident may have a negative interaction with. Resident #11's clinical record lacked any other documentation related to the incident occurring on 05/28/2025. (continued on next page)

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 06/11/2025
NAME OF PROVIDER OR SUPPLIER: Alpine Skilled Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 3101 Plumas St, Reno, NV 89509	

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/11/2025 at 1:59 PM, Resident #10 verbalized a few weeks prior, Resident #11 approached Resident #10 and called resident #10 derogatory names. Resident #10 yelled racial slurs in return. On 06/11/2025 at 2:05 PM, Resident #11 verbalized Resident #10 walked by Resident #11's room, stopped in the doorway and used racial profanity. The facility then asked Resident #11 to move rooms and requested the residents stay away from one-another. On 06/11/2025 at 3:43 PM, a Licensed Practical Nurse (LPN) verbalized two weeks prior Resident #11 was on the phone in the resident's room. Resident #10 stopped in Resident #11's doorway and used racial slurs toward Resident #11. The LPN explained the LPN was at the end of another hallway, heard the altercation, and was able to get to the residents quickly. Resident #11 has since been avoiding Resident #10. On 06/11/2025 at 5:55 PM the Abuse Coordinator who is the Director of Nursing (AC/DON) explained verbal abuse occurred when someone attacked or said something to make another person upset, particularly if the victim of the verbal abuse was vulnerable. The AC/DON verbalized it would not immediately be considered abuse if a staff member informed the AC/DON a resident raised their voice at another resident. The AC/DON verbalized the incident occurred in the hallway outside Resident #11's room. The two residents were yelling at one-another and the LPN on duty heard the commotion. The AC/DON explained because it was just a verbal altercation the facility did not do an official investigation, submit a Facility Reported Incident (FRI) report, nor make any notifications to the Ombudsman, the residents' families, or the Medical Director. On 06/11/2025 at 6:32 PM, the AC/DON explained a FRI investigation was to be completed within two hours of the facility being made aware. The AC/DON verbalized using racial slurs would be considered racially abusive language, bullying and harassment. The AC/DON confirmed racism was a pervasive issue in the facility and verbalized in healthcare, racially discriminatory behavior was normalized. The AC/DON explained when the AC/DON was informed of the incident on 05/28/2025, the AC/DON interviewed the LPN and determined the incident was not abuse. The AC/DON confirmed the verbal conversation with the LPN was not documented anywhere. The AC/DON verbalized there were multiple resident rooms between where the incident occurred and where LPN heard the incident down the hallway. The AC/DON did not speak with the residents involved, nor any other residents who may have heard. On 05/29/2025, one day after the incident, the Licensed Master Social Worker interviewed the residents and completed a trauma screening. There was no further investigation into the incident. The facility policy, titled Abuse Investigation and Reporting, adopted 02/01/2019, documented investigations into suspected abuse would include review of the resident's medical record and interviews with the reporter of the alleged abuse, witnesses, any involved residents, the physician, and the resident's family members. Notification would be made to the SA, the Ombudsman, the resident's representative, adult protective services, law enforcement, the resident's physician, and the Medical Director. All allegations of abuse would be reported no later than two hours. Cross reference with F550 and F657.

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

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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 interview, clinical record review, and document review, the facility failed to ensure a resident with a history of nicotine dependence had a care plan to address the resident's stated plans to continue smoking for 1 of 11 sampled residents (Resident #2). This deficient practice had the potential to result in facility staff being unaware of a resident's behavior and stated desire to continue smoking while wearing oxygen with the potential for the resident to suffer severe harm or death from burns as the result of smoking with oxygen in use from lack of care planned interventions to prevent adverse outcomes associated with the behavior. Findings include: Resident #2 Resident #2 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including nicotine dependence, cigarettes, uncomplicated and chronic obstructive pulmonary disease, unspecified. A Facility Reported Incident (FRI), dated 06/06/2025, documented the resident's wheelchair was on fire in the facility parking lot and the resident was on the ground next to the wheelchair. The resident had black and red discoloration to the skin of the resident's upper legs, abdomen, nostrils, and hands. The resident was crying and verbalizing pain all over. The resident was transported to the hospital via ambulance. A Physician's Order, dated 04/21/2025, documented oxygen administered via nasal cannula at 2 liters per minute as needed. A Behavior Note, dated 04/28/2025, documented the resident had stated the resident would take the oxygen to go outside but it would be the facility's fault if the resident blows up. The resident planned to go outside to smoke. The resident's need for oxygen was reviewed and the resident became more upset. A Communication Note, dated 05/07/2025, documented the resident had stated the resident did not understand why others were able to smoke but the resident was not able to smoke. The dangers of smoking with oxygen were discussed with the resident. A Nursing Narrative Note, dated 05/13/2025, documented the resident became verbally aggressive when the resident was told the resident was on isolation when the resident wanted to go outside for a cigarette. The resident stated the resident would smoke in the resident's bathroom. A Mental Health Exam, dated 05/31/2025, documented the resident was frustrated because the resident had not smoked in two days. A Medication Order, dated 06/01/2025, documented nicotine transdermal patch, apply 14 milligrams transdermal one time a day to try to quit smoking. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A provider's Progress Note, dated 06/04/2025, documented the resident was outside with smokers and was attempting to bum a smoke. The Care Plan for Resident #2 did not include a care plan related to the resident's risk factors of continuing to smoke while wearing oxygen. On 06/11/2025 at 11:58 AM, a Registered Nurse (RN) verbalized the resident had been told not to smoke on the facility property, but the RN was aware the resident had been seen smoking on property prior to the incident on 06/06/2025. The RN explained the RN had spoken to the resident on 06/05/2025 about the importance of quitting smoking. The RN verbalized the RN did not know if the resident's history of smoking on facility property would be care planned. On 06/11/2025 at 12:13 PM, the Director of Nursing (DON) verbalized the DON assumed the resident had been smoking while wearing oxygen on 06/06/2025, causing the fire and injuries to the resident. On 06/11/2025 at 1:51 PM, the DON verbalized the resident's history of smoking and risk factors associated with smoking while wearing oxygen could have been care planned. The facility policy titled Care Plan, Comprehensive Person-Centered, adopted 02/01/2019, documented the care plan would incorporate identified problem areas and their causes and develop targeted and meaningful interventions for the resident. FRI #NV00074424

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review, the facility failed to ensure resident care plans were updated after a resident-to-resident altercation for 2 of 11 sampled residents (Residents #10 and #11). This deficient practice has the potential to result in a resident not receiving care and services to meet their needs and prevent further altercations and psychosocial harm. Findings include: Resident #10 Resident #10 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of bipolar disorder, unspecified. A nursing narrative note, dated 05/28/2025, documented Resident #10 walked past another resident's room. The other resident was on the phone and yelled at Resident #10 to get away. Resident #10 yelled out a racial slur. The Nurse spoke with the other resident who confirmed the incident and verbalized doing their best to stay away from Resident #10, but Resident #10 kept coming back. The residents had a history involving the police. A communication note dated 05/29/2025, documented the Licensed Master Social Worker met with Resident #10 regarding the resident-to-resident interaction the previous day. They discussed the resident's ability to distance themselves from other people the resident may have a negative interaction with. Resident #10's care plan included a focus initiated on 12/05/2024, documenting Resident #10 demonstrated a potential for verbally aggressive behaviors as evidenced by yelling out related to a cognitive communication deficit and bipolar disorder. Resident #10's care plan lacked a revision on or after 05/28/2025 regarding the resident-to-resident altercation involving the use of a racial slur. Resident #11 Resident #11 was admitted to the facility on [DATE], with diagnoses including cognitive communication deficit and anxiety disorder, unspecified. A communication note dated 05/29/2025, documented the Licensed Master Social Worker met with Resident #11 regarding the resident-to-resident interaction the previous day. They discussed the resident's ability to distance themselves from other people the resident may have a negative interaction with. Resident #11's care plan with a focus initiated on 04/28/2024, and last revised on 04/03/2025, documented Resident #11 was at risk for adverse consequences of post-traumatic stress disorder related to a history of abuse and racial trauma. The care plan was not updated after the 05/28/2025 incident. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #11's care plan lacked a revision on or after 05/28/2025 regarding the resident-to-resident altercation involving the use of a racial slur. Resident #11's clinical record lacked any other documentation related to the incident occurring on 05/28/2025. On 06/11/2025 at 1:59 PM, Resident #10 verbalized a few weeks prior, Resident #11 approached Resident #10 and called resident #10 derogatory names. Resident #10 yelled racial slurs in return. On 06/11/2025 at 2:05 PM, Resident #11 verbalized Resident #10 walked by Resident #11's room, stopped in the doorway and used racial profanity. The facility then asked Resident #11 to move rooms and requested the residents stay away from one-another. On 06/11/2025 at 3:34 PM, a Certified Nursing Assistant (CNA) explained staff could view resident care plans to ascertain if resident needs changed and what actions staff were expected to take. The CNA explained Resident #10 had a history of yelling profanity. The CNA was unaware of any altercation between Residents #10 and #11. On 06/11/2025 at 3:43 PM, a Licensed Practical Nurse (LPN) verbalized two weeks prior, Resident #11 was on the phone in the resident's room. Resident #10 stopped in Resident #11's doorway and used racial slurs toward Resident #11. The LPN explained the LPN was at the end of another hallway, heard the altercation, and reached the residents quickly. After the altercation, Resident #11 avoided Resident #10. The LPN verbalized being unaware of any new interventions implemented after the altercation. On 06/11/2025 at 6:32 PM, the AC/DON verbalized care plans allowed staff to communicate resident needs and prevent accidents from occurring or recurring. The AC/DON verbalized care plans should be updated to document racial trauma and behavior related to racial discrimination. The AC/DON was unsure if Resident #10 or #11's care plans were updated after the 05/28/2025 incident. The facility policy titled Care Plan, Comprehensive Person-Centered, adopted 02/01/2019, documented the care plan would incorporate identified problem areas and their causes and develop targeted and meaningful interventions for the resident. Cross reference with F550 and F610.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review, the facility failed to ensure a resident with a history of nicotine dependence and stated plans to continue smoking was adequately supervised to prevent the resident from experiencing a preventable accident while smoking with oxygen in place for 1 of 11 sampled residents (Resident #2) and two residents were not near Resident #2 while the resident was smoking with oxygen in place (Resident #3 and #4). This deficient practice had the potential to result in residents suffering burns causing severe pain and a decline in quality of life. Findings include: Resident #3 Resident #3 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including multiple sclerosis, muscle weakness (generalized), and chronic obstructive pulmonary disease, unspecified. Resident #4 Resident #4 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary disease, unspecified and pain, unspecified. Resident #2 Resident #2 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including nicotine dependence, cigarettes, uncomplicated and chronic obstructive pulmonary disease, unspecified. A Facility Reported Incident (FRI), dated 06/06/2025, documented the resident's wheelchair was on fire in the facility parking lot and the resident was on the ground next to the wheelchair. The resident had black and red discoloration to the skin of the resident's upper legs, abdomen, nostrils, and hands. The resident was crying and verbalizing pain all over. The resident was transported to the hospital via ambulance. A Physician's Order, dated 04/21/2025, documented oxygen administered via nasal cannula at 2 liters per minute as needed. A Behavior Note, dated 04/28/2025, documented the resident had stated the resident would take the oxygen to go outside but it would be the facility's fault if the resident blows up. The resident planned to go outside to smoke. The resident's need for oxygen was reviewed and the resident became more upset. A Communication Note, dated 05/07/2025, documented the resident had stated the resident did not understand why others were able to smoke but the resident was not able to smoke. The dangers of smoking with oxygen were discussed with the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nursing Narrative Note, dated 05/13/2025, documented the resident became verbally aggressive when the resident was told the resident was on isolation when the resident wanted to go outside for a cigarette. The resident stated the resident would smoke in the resident's bathroom. A Mental Health Exam, dated 05/31/2025, documented the resident was frustrated because the resident had not smoked in two days. A Medication Order, dated 06/01/2025, documented nicotine transdermal patch, apply 14 milligrams transdermal one time a day to try to quit smoking. A provider's Progress Note, dated 06/04/2025, documented the resident was outside with smokers and was attempting to bum a smoke. The Care Plan for Resident #2 did not include a care plan related to the resident's risk factors of continuing to smoke while wearing oxygen. On 06/11/2025 at 11:58 AM, a Registered Nurse (RN) verbalized the resident had been told not to smoke on the facility property, but the RN was aware the resident had been seen smoking on property prior to the incident on 06/06/2025. The RN explained the RN had spoken to the resident on 06/05/2025 about the importance of quitting smoking. The RN verbalized the RN did not know if the resident's history of smoking on facility property would be care planned. On 06/11/2025 at 12:13 PM, the Director of Nursing (DON) verbalized the DON assumed the resident had been smoking while wearing oxygen on 06/06/2025, causing the fire and injuries to the resident. On 06/11/2025 at 12:36 PM, Resident #3 verbalized the resident had heard staff tell Resident #2 not to smoke many times, but the resident was regularly smoking in the parking lot. Resident #3 explained on 06/06/2025, Resident #2 was smoking in the parking lot and then the oxygen hose was on fire. Resident #3 saw Resident #4 get Resident #2 out of the resident's wheelchair and Resident #4 told Resident #3 to go get help. On 06/11/2025 at 12:41 PM, Resident #4 verbalized on 06/06/2025, Resident #2 was in the parking lot and attempted to light a cigarette. The resident explained everything was on fire. The resident verbalized the resident pulled Resident #2 out of the resident's wheelchair because the wheelchair was on fire and the resident wanted the oxygen tank attached to the wheelchair to be farther away from the residents. The resident explained the resident had seen Resident #2 smoking in the parking lot many times while wearing oxygen and had informed the office staff. On 06/11/2025 at 1:51 PM, the DON verbalized the resident's history of smoking and risk factors associated with smoking while wearing oxygen could have been care planned. The facility policy titled Care Plan, Comprehensive Person-Centered, adopted 02/01/2019, documented the care plan would incorporate identified problem areas and their causes and develop targeted and meaningful interventions for the resident. The facility policy titled Respiratory Therapy Policy - Oxygen Use, written 08/2024, documented clinical staff would ensure applicable precautions would be observed at all times. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Smoking Policy - Residents and Employees, adopted 03/2022, documented the facility was a smokefree environment, prohibiting smoking in all indoor and outdoor areas by residents. Residents refusing to follow safe smoking practices would be issued a 30-day notice for being a danger to self or others. FRI #NV00074424