

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 01/13/2025
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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848</p> <p>Based on observation, interview, and document review, the facility failed to ensure the facility's electronic health record was not left open and accessible on a computer attached to a medication cart with a resident's identifiers and medication administration record visible while staff were not in attendance or sight of the cart for 1 of 21 residents residing on the 800 hall (Resident #15). This deficient practice had the potential to result in a resident's confidential information being accessed by unauthorized individuals including other residents or visitors without the resident's permission.</p> <p>Findings include:</p> <p>Resident #15</p> <p>Resident #15 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including major depressive disorder, recurrent, moderate and bipolar disorder, unspecified.</p> <p>On 01/06/2025 at 8:58 AM, a computer located on top of a medication cart on the 800-hall had information for Resident #15 including the resident's name, picture, and current medications with associated diagnoses visible. There was not a staff member in front of the cart or visible from the cart.</p> <p>On 01/06/2025 at 9:00 AM, a Certified Nursing Assistant (CNA) walked by the cart and verbalized the Registered Nurse (RN) was attending to a resident on the 600 hall.</p> <p>The RN came from the direction of the 600 hall and confirmed the RN had left the resident information visible on the computer when the RN had walked away from the medication cart. The RN verbalized the RN should have ensured the resident information was not visible when the RN had walked away from the medication cart.</p> <p>On 01/09/2025 at 10:53 AM, the Director of Nursing (DON) verbalized resident's personal information and medical records were private and should not have been visible on an unattended computer. The DON verbalized when records were left open and unattended the records could be accessed by others and staff were responsible for ensuring the resident's electronic health record was not accessible to unauthorized individuals.</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
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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy titled Protected Health Information (PHI), Management and Protection of, adopted 02/01/2019, documented PHI would not be used or disclosed except as permitted by current federal and state laws. It was the responsibility of all personnel who had access to resident information to ensure such information was managed and protected to prevent unauthorized disclosure.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848</p> <p>Based on observation, interview, clinical record review and document review, the facility failed to ensure a comfortable ambient air temperature was provided to residents (Resident #59, #19, #76, #30, #123, #104, #1, #2, #106, and #41) using the communal shower rooms in 3 of 3 facility shower rooms with temperatures of 62.1 degrees Fahrenheit (F), 62.4 F, and 67.6 F. This deficient practice had the potential to cause residents widespread discomfort before, during and after showers.</p> <p>Findings include:</p> <p>Resident #59</p> <p>Resident #59 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including need for assistance with personal care and polyneuropathy, unspecified.</p> <p>On 01/07/2025 at 8:03 AM, Resident #59 verbalized it was a little chilly in the shower room and it was not very comfortable.</p> <p>Resident #19</p> <p>Resident #19 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including need for assistance with personal care and chronic obstructive pulmonary disease, unspecified.</p> <p>On 01/07/2025 at 8:07 AM, Resident #19 verbalized the resident had started showering in the sink in the resident's room because the shower room was not warm enough.</p> <p>Resident #76</p> <p>Resident #76 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including need for assistance with personal care and unspecified sequelae of cerebral infarction.</p> <p>On 01/07/2025 at 8:11 AM, Resident #76 verbalized the shower room was always cold, and the resident would refuse to take a shower some days because the shower room was freezing.</p> <p>On 01/07/2025 at 8:53 AM, a Certified Nursing Assistant (CNA) verbalized residents had complained to the CNA about the shower room being too cold and the CNA had informed Maintenance.</p> <p>On 01/07/2025 at 8:55 AM, a Registered Nurse (RN) verbalized residents had told the RN the residents did not like the shower room because it was not warm enough.</p> <p>On 01/07/2025 at 8:57 AM, an LPN verbalized when residents complained about the temperature in the shower room the complaint was passed on to Maintenance. The LPN verbalized the LPN agreed with the resident complaints of the room being too cold and felt the shower rooms were chilly.</p> <p>49557</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Resident #30</p> <p>Resident #30 was admitted to the facility on [DATE], with diagnoses including unspecified mononeuropathy of bilateral lower limbs and primary generalized osteoarthritis.</p> <p>On 01/07/2025 at 8:12 AM, Resident #30 verbalized Resident #30 had taken one shower since admission to the facility and had refused any more showers because the shower room was freezing.</p> <p>Resident #123</p> <p>Resident #123 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unstable burst fracture of first lumbar vertebra, subsequent encounter for fracture with routine healing and paraplegia, unspecified.</p> <p>On 01/07/2025 at 8:21 AM, Resident #123 verbalized the resident's last shower was approximately two weeks prior and the shower room was cold.</p> <p>31739</p> <p>Resident #104</p> <p>Resident #104 was admitted to the facility on [DATE], with diagnoses including fracture of one rib, left side, subsequent encounter for fracture with routine healing, unspecified fracture of unspecified pubis, subsequent encounter for fracture with routine healing, difficulty walking, and muscle weakness.</p> <p>On 01/07/2025 at 8:07 AM, Resident #104 verbalized having used the shower room and the room temperature felt cold. The resident verbalized not liking when it was cold, and it should have been warmer.</p> <p>Resident #1</p> <p>Resident #1 was admitted to the facility on [DATE], with diagnoses including paraplegia, unspecified, neuralgia and neuritis, unspecified, difficulty walking, and muscle weakness.</p> <p>On 01/07/2025 at 8:15 AM, Resident #1 verbalized having used the shower room and felt the room was cold resulting in the resident feeling uncomfortable.</p> <p>43311</p> <p>Resident #2</p> <p>Resident #2 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including metabolic encephalopathy and type two diabetes mellitus with diabetic nephropathy.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 01/06/2025 at 9:02 AM, Resident #2 explained the resident had complained of cold temperatures in the shower room since admission. The resident explained the resident had to decide to either shower and freeze or to not take a shower at all. The resident communicated the resident felt the resident had to suffer through the shower when the room did not feel as though there was any heat. Resident #2 expressed feeling dehumanized when the shower room was too cold for a shower.</p> <p>Resident #106</p> <p>Resident #106 was admitted to the facility on [DATE], with diagnoses including non-Hodgkin lymphoma, unspecified, unspecified site, and muscle weakness, generalized.</p> <p>On 01/07/2025 at 8:08 AM, Resident #106 communicated the shower room was too cold and the resident hated the idea of going into the shower rooms.</p> <p>Resident #14</p> <p>Resident #14 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including polyneuropathy, unspecified, other abnormalities of gait and mobility, and need for assistance with personal care.</p> <p>On 01/07/2025 at 8:13 AM, Resident #14 verbalized the shower room was freezing and not acceptable. Resident #14 verbalized reporting the cold shower room temperature to staff and the resident felt staff had not addressed the resident's concern as the resident felt the shower room was still too cold. Resident #14 explained the resident did not take showers in the shower rooms because of the cold ambient temperature and instead performed personal hygiene in the bathroom sink.</p> <p>Resident #41</p> <p>Resident #41 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including polyneuropathy, unspecified, unspecified sequelae of cerebral infarction, other abnormalities of gait and mobility, and need for assistance with personal care.</p> <p>On 01/07/2025 at 8:14 AM, Resident #41 communicated the resident felt the shower room temperatures were too cold to use for a shower.</p> <p>On 01/07/2025, the following ambient temperatures were taken in each facility unit shower room with Maintenance staff present to confirm findings:</p> <p>-7:29 AM Boundary Peak communal shower room: 62.1 F</p> <p>-7:37 AM [NAME] communal shower room: 62.4 F</p> <p>-8:52 AM [NAME] Peak communal shower room: 67.6 F</p> <p>On 01/07/2025 at 7:38 AM, the Maintenance Director confirmed a shower room temperature of 62.1 to 62.4 degrees F was chilly and would not like to take a shower in those temperatures. The Maintenance Director verbalized the Maintenance Director had thought the shower room ambient temperatures were fixed when the heaters were replaced last year.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 01/07/2025 at 8:53 AM, the Engineering Manager confirmed the ambient temperature of the shower rooms were too cold. The Engineering Manager explained the Engineering Manager would not want to take a shower in a cold shower room.</p> <p>On 01/07/2025 at 9:01 AM, a Licensed Practical Nurse (LPN) communicated the ambient temperatures in the shower rooms were too cold for showers.</p> <p>On 01/07/2025 at 9:14 AM, the Administrator explained the Administrator was unaware of the shower room ambient temperatures registering so low and the Administrator would not feel comfortable taking a shower in a room at the same temperatures. The Administrator confirmed the Director of Engineering was responsible for facility maintenance oversight.</p> <p>On 01/07/25 at 9:58 AM, the Owner explained the Owner was aware of the low ambient temperatures in the shower rooms and resident complaints regarding the shower room temperatures. The Owner explained the facility had been waiting for the vendor to show up after being closed for two weeks over the holidays. The Owner confirmed Maintenance did not measure the temperatures in the shower rooms. The Owner explained the facility had tried raising the heat temperatures universally within the facility and it heated up the hallways but the shower rooms had remained cold.</p> <p>On 01/07/2025 at 10:41 AM, six out of seven Resident Council attendees communicated the residents felt the unit shower rooms were too cold for showering.</p> <p>On 01/07/2025 at 12:14 PM, the Director of Engineering explained becoming aware the thermostat was not identifying proper temperatures on 12/19/2024. The Director of Engineering verbalized the Director of Engineering had called a repair company and thought the issue was fixed. The Director of Engineering verbalized Maintenance staff had not communicated the continued issue with low ambient temperatures in the shower rooms to the Director of Engineering.</p> <p>A facility policy titled Resident Rights, adopted 02/01/2019, documented federal and state laws guaranteed certain basic rights to all facility residents. The resident had a right to a safe, clean, comfortable, and homelike environment, including receiving treatment and support for daily living safely.</p> <p>A facility policy titled Quality of Life-Homelike Environment, adopted 02/01/2019, documented residents would be provided with a safe, clean, comfortable and homelike environment. The facility staff and management would maximize the characteristics of the facility to reflect a personalized, homelike setting to include comfortable and safe temperatures (71 degrees F to 81 degrees F).</p> <p>A facility policy titled Maintenance Service, adopted 02/01/2019, documented maintenance service would be provided to all areas of the building, grounds, and equipment. Maintenance personnel functions included maintaining the heat/cooling system, plumbing fixtures, and wiring in good working order.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557</p> <p>Based on observation, interview, clinical record review, and document review the facility failed to ensure a care plan was developed related to the care of a Foley catheter for 1 of 28 sampled residents (Resident #123). This deficient practice had the potential to result in residents not receiving care and services to meet their needs related to indwelling devices.</p> <p>Findings include:</p> <p>Resident #123</p> <p>Resident #123 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unstable burst fracture of first lumbar vertebra, subsequent encounter for fracture with routine healing and paraplegia, unspecified.</p> <p>On 01/06/2025 at 8:30 AM, Resident #123 had a Foley catheter in place. The drainage bag was secured to the bed frame, and clear yellow urine was in the bag. The resident verbalized the resident believed the drainage bag was not emptied often enough.</p> <p>A Minimum Data Set 3.0 (MDS) admission assessment, completed 11/06/2024, documented Resident #123 had an indwelling catheter.</p> <p>An MDS significant change in status assessment, completed 12/26/2024, documented Resident #123 had an indwelling catheter.</p> <p>On 01/07/2025 at 3:23 PM, during a review of Resident #123's Care Plan, the Care Plan included a focus area of enhanced barrier precautions related to catheter. Interventions included assessing the resident's comorbidities quarterly and as needed and enhanced barrier precautions per facility policy. The date initiated for the focus area and the interventions was 10/30/2024.</p> <p>The Care Plan lacked any other focus area, goals, or interventions related to care of the resident's catheter.</p> <p>On 01/09/2025 at 8:30 AM, a Licensed Practical Nurse (LPN) verbalized a Care Plan for a resident with a Foley catheter should include monitoring for signs and symptoms of infection, cleaning of the insertion site, assuring a privacy cover was in place over the drainage bag, keeping the drainage bag below the level of the bladder, and changing of the catheter.</p> <p>On 01/09/2025 at 1:42 PM, the Director of Nursing (DON) verbalized a Care Plan for a resident with a Foley catheter should include checking for kinks in the tubing, keeping the drainage bag off the floor, cleaning the catheter every shift, positioning the drainage bag below the level of the bladder, and observing for signs and symptoms of a urinary tract infection. The DON confirmed Resident #123 had a Foley catheter in place and a Care Plan should have been developed related to care of the resident's catheter. The DON reviewed Resident #123's Care Plan and verbalized a focus area related to care of the resident's catheter was added on 01/07/2024.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/09/2025 at 2:48 PM, the Regional MDS Nurse verbalized a Care Plan related to care of Resident #123's Foley catheter was developed 01/07/2025, however the resident had the catheter in place prior to 01/07/2025 and the Care Plan was not developed timely.</p> <p>The facility policy titled Care Plans, Comprehensive Person-Centered, dated 02/01/2019, documented the Interdisciplinary Team (IDT) would develop and implement a comprehensive, person-centered care plan for each resident. The care plan would include measurable objectives and timetables to meet the resident's needs, incorporate identified problem areas, and incorporate risk factors associated with identified problems. The IDT was to review and update the care plan when there was a significant change in the resident's condition, when the resident was readmitted to the facility from a hospital stay, and at least quarterly.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557</p> <p>Based on interview, clinical record review, and document review the facility failed to ensure a care plan was updated to include new interventions for the prevention of falls for 1 of 28 sampled residents (Resident #448). This deficient practice had the potential to result in residents not receiving care and services to meet their needs and help prevent falls.</p> <p>Findings include:</p> <p>Resident #448</p> <p>Resident #448 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including metabolic encephalopathy and other osteonecrosis, right femur.</p> <p>Fall Risk Evaluations dated 12/20/2024, 12/28/2024, and 01/02/2025 documented Resident #448 was a high risk for falling.</p> <p>A progress note dated 12/20/2024, documented Resident #448 had a fall. The resident reported the resident slipped during transfer and agreed to ask for assistance with transfers in the future.</p> <p>A progress note dated 01/02/2025, documented Resident #448 had a fall. The resident sustained no injuries.</p> <p>Resident #448's Care Plan included a focus area of fall risk related to confusion and deconditioning. The date initiated was 12/23/2024. Interventions included the following:</p> <ul style="list-style-type: none"> -12/20/2024 Unwitnessed fall without injury. Remind resident to ask for help with transfers. -Follow facility fall protocol. -Neurological checks and vital signs per facility policy post fall. Notify physician of significant abnormalities. -Physical Therapy to evaluate and treat as ordered or as needed. <p>The date initiated for all interventions was 12/23/2024.</p> <p>On 01/08/2025 at 10:36 AM, a Licensed Practical Nurse (LPN) verbalized Resident #448 was a high risk for falls due to confusion and being impulsive. The LPN recalled Resident #448 had a fall on 01/02/2024. The LPN verbalized to help prevent falls the LPN was checking on Resident #448 frequently and offering activities near the nurses' station to keep the resident busy.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/13/2025 at 9:50 AM, the Director of Nursing (DON) explained the facility's process when a resident fell was to assess the resident for injuries, assist the resident to a safe place such as a chair or the resident's bed, notify the resident's family and physician and document in a progress note. The facility's risk management team reviewed each fall and assured proper interventions were in place to help prevent future falls. The DON verbalized it was part of the facility's process to update the resident's care plan after a fall with new or revised interventions.</p> <p>The DON verbalized Resident #448 had fallen in the facility on 12/20/2024 and on 01/02/2025. The DON explained the resident was reaching for the resident's phone when the resident fell on [DATE]. The DON reviewed Resident #448's Care Plan and confirmed the Care Plan was not updated after the fall on 01/02/2025. The DON verbalized an intervention to place the resident's belongings within reach should have been added to the Care Plan.</p> <p>The facility policy titled Fall Prevention and Management, dated 02/01/2019, documented residents identified as high risk would be care planned and individualized precautions would be noted to avoid falls. Following a fall, staff were to make appropriate interventions to prevent reoccurrence of a fall or to minimize injury and update the resident's Care Plan.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557</p> <p>Based on interview, clinical record review, and document review the facility failed to ensure physician ordered wound care was performed for 1 of 28 sampled residents (Resident #448). This deficient practice had the potential for a resident's wound to worsen and/or delay healing.</p> <p>Findings include:</p> <p>Resident #448</p> <p>Resident #448 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including metabolic encephalopathy and other osteonecrosis, right femur.</p> <p>On 01/06/2025 at 9:05 AM, Resident #448 had a dressing covering the resident's right elbow. The dressing had a date of 01/05/2025 written on it.</p> <p>A physician's order dated 01/01/2025, documented wound treatment: clean right elbow skin tear with Normal Saline (NS), pat dry, apply xeroform sheet to area, cover with silicone dressing daily and as needed (PRN) if dressing becomes soiled or dislodged, every day shift.</p> <p>Resident #448's January Treatment Administration Record (TAR) lacked documented evidence wound care was provided to the resident's right elbow on 01/04/2025.</p> <p>On 01/08/2025 at 10:41 AM, a Licensed Practical Nurse (LPN1) verbalized Resident #448 had a wound on the resident's right elbow and floor nurses were providing wound care. The LPN1 explained the nurses documented wound care in the TAR or progress notes.</p> <p>On 01/09/2025 at 8:39 AM, an LPN2 confirmed the LPN2 was assigned to care for Resident #448 on 01/04/2025. The LPN2 verbalized Resident #448's TAR indicated the resident had a skin tear on the resident's right elbow. The LPN2 denied the LPN2 provided wound care to the resident's right elbow on 01/04/2025, and explained the LPN2 was unaware the resident had the wound until 01/09/2025.</p> <p>On 01/09/2025 at 10:55 AM, the Director of Nursing (DON) verbalized wounds could deteriorate or get worse if physician ordered wound care was not provided/performed.</p> <p>On 01/09/2025 at 1:52 PM, during an interview with the DON and the Administrator, the DON reviewed Resident #448's TAR and confirmed the TAR lacked documentation of wound care being provided to the resident's right elbow on 01/04/2025. The DON confirmed Resident #448 had an active physician's order for daily wound care and should have received wound care on 01/04/2025.</p> <p>The facility policy titled Skin and Wound Management, last revised 01/11/2024, documented each resident with skin breakdown would receive services and treatment to prevent infection and promote wound healing.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>49557</p> <p>Based on observation, interview, and document review the facility failed to ensure current nursing hours were posted for the facility. This deficient practice had the potential to result in a lack of awareness for residents and visitors regarding the number of nursing staff on duty.</p> <p>Findings include:</p> <p>On 01/05/2025 at 10:22 AM, the nursing staff posting for the facility, located in the hallway near the entrance to the facility, was dated 01/03/2025.</p> <p>On 01/05/2025 at 10:55 AM, the Director of Nursing (DON) verbalized the DON believed the staffing posting was only posted in one location, the hallway near the main entrance to facility, not on each unit.</p> <p>On 01/05/2025 at 10:56 AM, the Administrator verbalized the staff posting was supposed to be updated daily. The Administrator confirmed the staff posting for the facility was dated 01/03/2025, was not current, and should have been removed and updated for 01/05/2025. The Administrator confirmed the daily nursing staff posting was only posted in one location, in the hallway near the entrance to building, and was not posted on each unit throughout the facility.</p> <p>The facility policy titled Posting Direct Care Daily Staffing Numbers, revised 08/02/2019, documented the facility would post, on a daily basis for each shift, the number of nursing personnel responsible for direct care to residents.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43311</p> <p>Based on observation and interview, the facility failed to ensure expired medications were removed from 2 of 3 medication storage rooms, and a wound care cart containing potentially hazardous opened treatment items remained secured. The opened items in the unsecured wound care cart had the potential to be available to resident's in and around the 400 Hall and the 400 Hall nurses' station.</p> <p>Findings include:</p> <p>Expired Medication</p> <p>On 01/09/2025 at 7:59 AM, the following expired medications were located in the [NAME] medication storage room:</p> <ul style="list-style-type: none"> -Geri Care Iron Liquid Supplement, one 16 ounce (oz) bottle, expired 12/2024. -Tubersol tuberculin purified protein derivative five tub (T) unit (U) per 0.1 milliliters vial, three vials, all vials opened and unmarked with a date of opening. <p>On 01/09/2025 at 8:03 AM, the Unit Manager (UM) confirmed the Iron Liquid Supplement had expired 12/2024. The UM also confirmed none of the three vials of Tubersol were marked with a date of opening and would be considered expired as there was no way of knowing how long the vials had been opened. The UM verbalized a multi-unit dose vial would be considered expired 30 days after the date of opening.</p> <p>On 01/09/2025 at 11:26 AM, one 16 oz bottle of Iron Liquid Supplement was located in the Boundary Peak medication storage room and had an expiration date of 12/2024.</p> <p>On 01/09/2025 at 11:30 AM, the Director of Nursing (DON) confirmed the bottle of Iron Liquid Supplement had expired 12/2024. The DON verbalized the consequences of taking an expired medication was the medication may cause an adverse reaction or not be as effective for treatment.</p> <p>The facility policy titled Storage of Medication, adopted 02/01/19, documented the facility did not use outdated drugs or biologicals. All outdated drugs were returned to the pharmacy or destroyed.</p> <p>31739</p> <p>Wound Care Cart</p> <p>On 01/05/2025 at 10:20 AM, a wound care cart located next to the nurses' station near the 400 Hall was unlocked. The nurses' station was unattended and there were no residents visibly in the area.</p> <p>The following opened items were located in the cart:</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-16-ounce bottle of Patrin Pharma H-Chlor 12 (sodium hypochlorite), 0.125 percent (%) solution, located in the second drawer. The bottle's label documented for topical use only, if swallowed contact poison control immediately.</p> <p>-50-gram jar of Dr. Reddy's SSD Silver Sulfadiazine 1% topical cream, located in the top drawer. The jar's label documented for topical use only, not for ophthalmic use.</p> <p>-100-gram tube of Cipla diclofenac sodium topical gel 1%, located in the top drawer. The tube's label documented for topical use only, not for ophthalmic use.</p> <p>On 01/05/2025 at 10:22 AM, the Licensed Practical Nurse (LPN) administering medications on the 400 Hall, confirmed the cart was unlocked and contained the opened items listed above. The LPN confirmed the items could have possibly been hazardous to a resident if consumed. The LPN verbalized the LPN did not have a key to the cart and the cart had been left opened as the LPN had scheduled wound care treatments to administer later in the day. The LPN confirmed the cart should have been locked and locked the cart.</p> <p>On 01/05/2025 at 11:32 AM, the Administrator verbalized additional keys of the wound care cart were made approximately two weeks previous, and all nursing staff were provided a key, including the LPN administering medications on the 400 Hall, to ensure the wound care cart remained locked when not in use.</p> <p>The facility policy titled, Storage of Medication, adopted 02/01/2019, documented nursing staff would be responsible for maintaining medication storage, carts would be locked when not in use, and carts shall not be left unattended if opened or otherwise potentially available to others.</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848</p> <p>Based on observation, interview, clinical record review, and document review, the facility failed to ensure a resident's requests for a dentist appointment to address broken teeth and pain with chewing food were addressed and efforts were made to schedule the resident for a dental appointment for 1 of 28 sampled residents (Resident #59). This deficient practice had the potential to result in a resident with dental concerns experiencing increased pain with chewing food or infection from cracked and broken teeth.</p> <p>Findings include:</p> <p>Resident #59</p> <p>Resident #59 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including need for assistance with personal care, type II diabetes mellitus with other specified complication, and other specified sepsis.</p> <p>On 01/06/2025 at 8:33 AM, Resident #59 verbalized the resident had been asking to see a dentist since May of 2024. The resident explained the resident had chipped and broken teeth causing the resident to have difficulty with chewing food and sometimes experienced tooth related pain. The resident verbalized the resident had told the nursing staff when admitted to the facility in May of 2024, the resident wanted to see a dentist. The resident had also requested to see a dentist when the resident spoke with a staff member from social services a couple of times. The resident verbalized the facility had not communicated to the resident whether any effort had been made to schedule a dental appointment for the resident or if there were any barriers to the resident receiving dental care.</p> <p>A Minimum Data Set (MDS) note, dated 05/11/2024, documented during the MDS admission interview Resident #59 verbalized having oral pain, chipped teeth, and discomfort. The resident had difficulty chewing.</p> <p>An MDS note, dated 05/16/2024, documented the resident verbalized the resident had oral pain due to chipped teeth.</p> <p>A care plan, initiated 05/23/2024, documented Resident #59 had oral/dental health problems (chipped teeth). A care plan intervention, initiated 05/23/2024, documented to coordinate arrangement for dental care, transportation as needed/as ordered.</p> <p>An MDS note, dated 06/19/2024, documented the resident reported mouth pain related to broken and missing teeth. The resident's teeth appeared carious and affected the resident's chewing.</p> <p>An order for Resident #59, dated 10/16/2024, documented dental care as needed.</p> <p>A Social Services Note, dated 11/19/2024, documented the resident was requesting dental services. Social Services sent referral.</p> <p>(continued on next page)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/08/2025 at 11:34 AM, the Licensed Practical Nurse (LPN) for Resident #59 verbalized when a resident requested a dental appointment the nurse would notify Social Services.</p> <p>On 01/08/2025 at 11:46 AM, the Social Worker for Resident #59 verbalized the Social Worker would notify the Social Work Coordinator (SWC) to send the referral.</p> <p>On 01/08/2025 at 11:48 AM, the SWC verbalized the SWC sent a request to Transportation Services (TS) on 11/19/2024.</p> <p>On 01/08/2025 at 11:51 AM, the TS verbalized the TS did not have a request to schedule a dentist appointment for Resident #59. The TS explained the TS would call and schedule an appointment once the TS receives the request. The TS verbalized the TS documentation did not have a note regarding scheduling a dental appointment for Resident #59.</p> <p>On 01/09/2025 at 9:09 AM, the TS verbalized the TS would input a note if a resident still needed an appointment. The TS verbalized the resident had an appointment request entered on 11/19/2024, but the request was crossed out because it was a duplicate request. The TS verbalized the Transportation Log did not have any documentation indicating the resident still needed an appointment.</p> <p>The Transportation Log documented the following two entries requesting dental appointments for Resident #59:</p> <ul style="list-style-type: none"> - a request on 08/19/2024 documented broken teeth had been causing the resident pain. - a request on 11/19/2024 documented the resident had Medicaid and needed to see a dentist for an exam. The entry was crossed out. <p>On 01/09/2024 at 10:44 AM, the Director of Nursing (DON) verbalized it would be important for the resident to be seen by a dentist for the resident's well being and to ensure the resident was not in pain. The DON verbalized if the facility was unable to schedule a dental appointment for the resident, then the facility should have been documenting the reason for any delays.</p> <p>The facility policy titled Dental Services, adopted 02/01/2019, documented routine and emergency dental services were available to meet the resident's oral health needs in accordance with the resident's assessment and plan of care. Social services representatives would assist residents with appointments, transportation arrangements, and for reimbursement of dental services under the state plan, if eligible.</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43311</p> <p>Based on observation, document review, and interview the facility failed to demonstrate effective administration by not ensuring the Administrator and the Director of Engineering adequately addressed the low ambient temperatures in 3 of 3 shower rooms.</p> <p>Findings include:</p> <p>On 01/07/2025, the following shower room ambient temperatures were taken with facility Maintenance staff present to confirm findings:</p> <p>-7:29 AM Boundary Peak communal shower room: 62.1 degrees Fahrenheit (F)</p> <p>-7:37 AM [NAME] communal shower room: 62.4 degrees F</p> <p>-8:52 AM [NAME] Peak communal shower room: 67.6 degrees F</p> <p>On 01/07/2025 at 9:14 AM, the Administrator explained the Administrator was unaware of the shower room ambient temperatures registering so low and the Administrator would not feel comfortable taking a shower in a room at the same temperatures. The Administrator confirmed the Director of Engineering was responsible for facility maintenance oversight.</p> <p>On 01/07/2025 at 12:14 PM, the Director of Engineering explained becoming aware the thermostat was not identifying proper temperatures on 12/19/2024. The Director of Engineering verbalized the Director of Engineering had called a repair company and thought the issue was fixed. The Director of Engineering verbalized Maintenance staff had not communicated the continued issue with low ambient temperatures in the shower rooms to the Director of Engineering.</p> <p>A job description titled Director of Engineering, undated, documented the Director of Engineering managed contracts and follow-up with work performed by outside vendors, ensured the facilities were in good shape, and ensured Plant Operations Managers were completing work orders timely. The position was responsible for overseeing all physical areas of the facility were maintained in good function and presentation.</p> <p>A job description titled Administrator, dated 08/01/2024, documented the primary purpose of the position was to direct the day-to-day facility functions to assure the highest degree of quality care could be provided to residents. The Administrator would consult with department managers and directors concerning the operation of those departments to assist in eliminating/correcting problem areas, and/or improvement of services. The Administrator would review and check workforce competence and make necessary adjustments/corrections as required or that may become necessary.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31739</p> <p>Based on clinical record review, interview and document review, the facility failed to ensure 4 of 28 sampled residents clinical records were completed for pressure wound treatments (Resident #3), surgical wound treatments (Resident #198 and #133), and skin tear wound treatments (Resident #448).</p> <p>Findings include:</p> <p>Resident #3</p> <p>Resident #3 was admitted to the facility on [DATE], with diagnoses including spastic quadriplegic cerebral palsy and pressure ulcer of sacral region, stage 3.</p> <p>Resident #3's November 2024 TAR documented wound care treatment: clean sacrum pressure injury with normal saline, pat dry, apply honey gel to area, follow by calcium alginate sheet, cover w/silicone dressing, daily and as needed if dressing becomes soiled or dislodged, every day shift. There was no wound treatment documented on 11/01/2024, 11/10/2024, and 11/19/2024 through 11/27/2024.</p> <p>Resident #3's December 2024 TAR documented wound care treatment: clean sacrum pressure injury with normal saline, pat dry, apply santyl to area, follow by calcium alginate sheet, cover with silicone dressing, daily and as needed if dressing becomes soiled or dislodged every day shift. There was no wound treatment documented on 12/03/2024, 12/12/2024, 12/17/2024, 12/18/2024, 12/23/2024, 12/24/2024, and 12/27/24.</p> <p>Resident #3's January 2025 Treatment Administration Record (TAR) documented wound care treatment: clean sacrum pressure injury with normal saline, pat dry, pack with Hydrofera Blue (activate with normal saline), cover with silicone dressing, Monday, Wednesday, Friday, and as needed, every day shift, for treatment. There was no wound treatment documented on 01/01/2025, 01/03/2025, or 01/06/2025.</p> <p>On 01/09/2025 at 10:27 AM, the Licensed Practical Nurse (LPN) Wound Care Nurse verbalized having provided care to Resident #3's sacral wound and forgot to document the treatments in the resident's record for the months of November 2024, December 2024, and January 2025.</p> <p>On 01/09/2025 at 11:12 AM, the Director of Nursing (DON) confirmed the wound care treatments for Resident #3's sacral pressure wound had not been documented in the resident's clinical records.</p> <p>30748</p> <p>Resident #198</p> <p>Resident #198 was admitted to the facility on [DATE], with diagnoses including fusion of the spine, lumbar region, encounter for orthopedic aftercare, other spondylosis, lumbar region, and intervertebral dis disorders with radiculopathy, lumbar region.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #198's December 2024 Treatment Administration Record (TAR) documented wound treatment: clean left lower back surgical incision with normal saline, pat dry, apply skin, cover with island dressing every Monday, Wednesday, and Friday, and as needed if dressing becomes soiled or dislodged. The start date was 12/20/2024. There was no wound treatment documented for 12/23/2024.</p> <p>Resident #198's December 2024 TAR documented wound treatment: clean right lower back surgical incision with normal saline, pat dry, apply skin, cover with island dressing every Monday, Wednesday, and Friday, and as needed if dressing becomes soiled or dislodged. The start date was 12/20/2024. There was no wound treatment documented for 12/23/2024.</p> <p>Resident #198's January 2025 TAR documented wound treatment: clean right lower back surgical incision with normal saline, pat dry, apply mupirocin ointment, cover with silicone dressing. Daily and as needed if dressing becomes soiled or dislodged. The start date was 12/28/2024. There was no wound treatment documented for 01/02/2025 and 01/06/2025.</p> <p>On 01/09/2025 at 10:00 AM, the LPN Wound Care Nurse explained the LPN Wound Care Nurse was responsible for all resident wound care every week, Monday through Friday. The wound care provided to the resident, would be documented in the resident TAR by the end of the day, documenting wound care had been completed.</p> <p>The LPN Wound Care Nurse verbalized Resident #198's physician's orders documented to cleanse the left and right lower back surgical incisions with normal saline, pat dry, apply skin, cover with island dressing every Monday, Wednesday, and Friday, and as needed if dressing becomes soiled or dislodged. The physician's orders had a start date of 12/20/2024. The order was then discontinued on 12/28/2024 and replaced with a new order on 12/28/2024. The new physician's order documented clean right lower back surgical incision with normal saline, pat dry, apply mupirocin ointment, cover with silicone dressing. Daily and as needed if dressing becomes soiled or dislodged.</p> <p>The LPN Wound Care Nurse confirmed the December TAR for Resident #198 lacked documented evidence wound care was provided on 12/23/2024 and the January TAR lacked documented evidence wound care was provided on 01/02/2025 and 01/06/2025. The LPN Wound Care Nurse verbalized there was no proof the wound care was provided to Resident #198 on those days.</p> <p>49557</p> <p>Resident #448</p> <p>Resident #448 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including metabolic encephalopathy and other osteonecrosis, right femur.</p> <p>Resident #448's January 2025 TAR documented wound treatment: clean right elbow skin tear with normal saline, pat dry, apply Xeroform sheet to area, cover with silicone dressing daily and as needed if dressing becomes soiled or dislodged. The start date was 01/02/2025. There was no wound treatment documented for 01/02/2025 and 01/03/2025.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/09/2025 at 10:14 AM, the LPN Wound Care Nurse verbalized the LPN Wound Care Nurse was responsible to provide wound treatment to residents on the days the LPN Wound Care Nurse worked, Monday through Friday. The LPN Wound Care Nurse confirmed Resident #448's January 2025 TAR lacked documented evidence wound care was provided on 01/02/2025 and 01/03/2025. The LPN Wound Care Nurse explained the LPN Wound Care Nurse had provided wound treatment to Resident #448's right elbow on 01/02/2025 and 01/03/2025 and had forgotten to document the care provided.</p> <p>Resident #133</p> <p>Resident #133 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including polyneuropathy, unspecified and postlaminectomy syndrome, not elsewhere classified.</p> <p>Resident #133's January 2025 TAR documented wound treatment: clean right hip wound with normal saline, pat dry, apply honey gel to area, follow by calcium alginate sheet, cover with silicone dressing. Daily and as needed, every day shift. The start date was 12/28/2024. There was no wound treatment documented for 01/02/2025 and 01/03/2025.</p> <p>On 01/09/2025 at 10:01 AM, the LPN Wound Care Nurse verbalized the LPN Wound Care Nurse was responsible to provide wound treatment to residents on the days the LPN Wound Care Nurse worked, Monday through Friday. The LPN Wound Care Nurse confirmed Resident #133's January 2025 TAR lacked documented evidence wound treatment was provided on 01/02/2025 and 01/03/2025. The LPN Wound Care Nurse explained the LPN Wound Care Nurse had provided wound treatment to Resident #133's right hip on 01/02/2025 and 01/03/2025 and did not document the care provided.</p> <p>On 01/09/2025 at 10:55 AM, the Director of Nursing (DON) explained the DON's expectation of nursing staff after providing wound care to residents was to document the care provided as soon as possible and before the end of the nurses' shift. The DON confirmed nurses were expected to chart on the resident's TAR when wound care was provided and verbalized a blank space on a resident's TAR indicated the nurse forgot to chart the care provided.</p> <p>The facility policy titled Charting and Documentation, dated 02/01/2019, documented all services provided, objective observations and treatments performed were to be documented in the resident's medical record.</p> <p>The facility policy titled Wound Care, dated 02/01/2019, documented the type of wound care given, date and time wound care was given and the name and title of the person performing the wound care were to be recorded in the resident's medical record.</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 01/13/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31739</p> <p>Based on observation, clinical record review, interview, and document review, the facility failed to ensure an employee donned proper personal protective equipment (PPE) prior to entering a resident's room on isolation contact-based precautions for 1 of 2 residents on contact-based precautions (Resident #119). This deficient practice of lack of proper infection control practices had the potential to spread infection and affect all residents within the facility.</p> <p>Findings include:</p> <p>Resident #119</p> <p>Resident #119 was admitted to the facility on [DATE], with diagnoses including methicillin-resistant staphylococcus aureus (MRSA), urinary tract infection, recurrent, major depressive disorder, unspecified, difficulty walking, and muscle weakness.</p> <p>On 01/06/2025 at 8:02 AM, a Social Services employee opened the door and walked into room [ROOM NUMBER], Resident #119's room. The room's door had a contact-based precautions sign posted on the outside of the door. The sign documented the room was on contact-based insolation precautions and to visit the nurses' station for information on the isolate precautions and documented illustrated examples of the required PPE to don and how to don prior to entering the room.</p> <p>On 01/06/2025 at 8:04 AM, in the presence of a Licensed Practical Nurse (LPN), the Social Services employee exited room [ROOM NUMBER] and closed the door.</p> <p>The Social Services employee confirmed knowing room [ROOM NUMBER] was on isolation precautions and confirmed not having donned PPE prior to entering the room, only having used alcohol-based hand rub. The Social Services employee verbalized not needing to don PPE as the employee had not provided care to the resident.</p> <p>The LPN verbalized to the Social Services employee the requirement for PPE, including the washing of hands, prior to entering room [ROOM NUMBER], was illustrated on the outside of the door, and all employees and visitors were to don PPE prior to entering and doff prior to exiting.</p> <p>On 01/06/2025 at 8:09 AM, the Director of Nursing (DON) verbalized the Social Services employee should have donned PPE before entering room [ROOM NUMBER] to prevent the spread of infection and all staff were expected to follow proper isolation precaution procedures.</p> <p>On 01/06/2025 at 2:56 PM, Resident #119 verbalized not having been sure if all persons entering the resident's room had on gowns and gloves.</p> <p>The facility policy titled, Isolation-Transmission-Based Precautions, adopted 02/01/2019, documented staff were to adhere to the appropriate hand hygiene and PPE procedures; when contact precaution were to implemented, staff and visitors were to perform proper hand hygiene, wear gloves and disposable gowns when entering the room and remove gloves and disposable gown and perform hand hygiene before leaving the room.</p>		