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 04/02/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to follow infection control guidelines. Specifically, staff failed to properly disinfect goggles used in droplet precaution isolation rooms for 3 of 9 residents (Resident (R) 34, R51, and R77), failed to wear the required mask while in a droplet precaution isolation room for 1 of 9 residents (R34), and failed to ensure glucometer [blood sugar testing device] checks were performed in a manner to prevent infection for one resident (R60). These failures had the potential to result in the spread of infection to staff and residents.Findings include: 1. Review of R34's admission Record located under the Profile tab in the electronic medical record (EMR) indicated R34 was admitted to the facility on [DATE] with diagnoses of Parkinson's disease and severe protein calorie malnutrition. Review of R34's Nursing Progress Notes located under the Progress Note tab in the EMR and dated 03/23/26 at 3:29 PM indicated R34 tested positive for COVID-19. During an observation on 03/30/26 at 9:53 AM, Certified Nursing Aide (CNA) 6 exited R34's room and removed the goggles she had worn while providing care to the resident. CNA6 wiped the goggles for 90 seconds with a Sani-Cloth wipe from the orange-top container and then placed the goggles directly into the isolation cart with clean, unused personal protective equipment (PPE). During an observation on 03/30/26 at 10:00 AM, Housekeeper (HSKP) 1 came out of R34's room, took off the goggles that she had worn into the resident's room, and began to clean them with a Sani-Cloth from the orange-top container for 90 seconds. After cleaning the goggles, HSKP1 placed them in the isolation cart with the unused, clean PPE. During an observation on 03/30/26 at 2:30 PM, Occupational Therapist (OT) was observed in R34's room assisting the resident with therapy wearing a surgical mask. 2. Review of R51's admission Record located under the Profile tab in the EMR indicated R51 was admitted to the facility on [DATE] with diagnoses of unspecified sequelae of other nontraumatic intracranial hemorrhage and atrial fibrillation. Review of R51's Nursing Progress Notes located under the Progress Note tab in the EMR and dated 03/25/26 at 3:31 PM indicated R51 tested positive for COVID-19. Review of R51's Physician Orders located under the Orders tab in the EMR indicated an order dated 03/25/26 which stated, Resident on Contact/Droplet Isolation 10-Day monitoring, COVID positive. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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 04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 03/30/26 at 10:05 AM, CNA6 exited R51's room and removed the goggles she had worn while providing care to R51. CNA6 wiped the goggles with a Sani-Cloth wipe from the orange-top container for 90 seconds and then placed the goggles directly into the isolation cart with clean, unused PPE. 3. Review of R77's admission Record located under the Profile tab in the electronic medical record (EMR) indicated R77 was admitted to the facility on [DATE] with the diagnosis of chronic obstructive pulmonary disease (COPD). Review of R77's Nursing Progress Notes located under the Progress Note tab in the EMR and dated 03/23/26 at 3:34 PM indicated R77 tested positive for COVID-19. Review of R77's Physician Orders located under the Orders tab in the EMR indicated an order dated 03/23/26 which stated, Resident on Contact/Droplet Isolation 10-Day monitoring, COVID positive. During an observation on 03/30/26 at 10:30 AM, CNA6 exited R77's room and removed the goggles she had worn while providing care to R77. CNA6 wiped the goggles with a Sani-Cloth wipe from the orange-top container for 90 seconds and then placed the goggles directly into the isolation cart with clean, unused PPE. During an interview on 03/30/26 at 10:45 AM, HSKP1 was asked how long she needed to clean the goggles she wore in a COVID-positive resident's room with a wet Sani-Cloth wipe from the orange-top container. HSKP1 stated, I don't understand what you are asking. During an interview on 03/30/26 at 10:50 AM, CNA6 was asked how long she needed clean the goggles with a wet Sani-Cloth wipe from the orange container before putting them in the isolation cart with the clean PPE items. CNA6 stated, I believe the time for the orange top is two to four minutes. During an interview on 03/31/26 at 3:10 PM, the Infection Preventionist (IP) stated the contact/cleaning time for the orange top container of Sani-Cloths is four minutes. The IP confirmed the staff should have cleaned the goggles with a wet Sani Cloth that came from the orange top container for four minutes. The IP was notified also of the OT wearing a surgical mask in R34's room, and she confirmed that the OT should have worn an N95 mask and not the surgical mask. Review of the undated facility's guide for Using the Correct Cleaning Wipes indicated, There are 3 approved wipes that should be used in the Facility to ensure infection control and prevention practice are happening at all time . Sani-Cloths Bleach [orange top] . contact time 4 mins. [minutes] . Review of the facility's policy Isolation-Transmission-Based Precautions, dated 01/09/26, indicated, . The Centers for Disease Control and Prevention (CDC) maintains a list of diseases, modes of transmission, recommended precautions, and recommendations for discontinuation . Droplet Precautions . Staff and visitors wear masks when entering the room . Review of the Infection Control Guidance: SARS-CoV-2 dated 06/24/24 and located at https://www.cdc.gov/covid/hcp/infection-control/index.html indicated, HCP [Healthcare Personnel] who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of the admission Record located in the Profile tab of the EMR revealed R60 was admitted to the facility with a diagnosis of diabetes. During an observation on 04/01/26 at 4:51 PM, Licensed Practical Nurse (LPN) 2 was observed at the medication cart. LPN2 removed the glucometer machine from the top drawer on the left and placed the machine on top of the medication cart without a barrier. She then placed the machine into her left pocket and applied gloves without using hand sanitizer prior and proceeded into R60's room with her supplies. R60 then placed the machine on R60's overbed table. After acquiring the blood sugar results, LPN 2 returned to the medication cart and placed the glucometer back into the drawer without cleaning it. During an interview on 04/01/26 at 5:00 PM, LPN2 confirmed that she placed the glucometer on the resident's overbed table without a barrier and that she placed it back into the drawer on the medication cart without cleaning it first. LPN2 stated, I should have cleaned the glucometer with the specialized wipes that are on the cart. LPN2 was asked if she had attended any in-services on infection control for the medication pass. LPN 2 stated, It's been a while. During an interview on 04/01/26 at 6:14 PM, Licensed Practical Nurse/Unit Manager (LPNUM) 1 confirmed that LPN2 did not maintain infection control practices during a glucometer check.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, document review, and review of McGeer's criteria, the facility failed to have an Antibiotic Stewardship Program consistent with current standards of practice for the prescribing of an antibiotic for 4 of 4 residents (Resident (R) 83, R33, R126, and R85) reviewed for antibiotic stewardship out of a total sample of 33 residents. This failure had the potential to result in the unnecessary use of antibiotics, increasing the risk of antibiotic resistance and adverse medication-related side effects for residents. Findings include:1. Review of R83's undated admission Record located under the Profile tab in the electronic medical record (EMR) indicated R83 was admitted to the facility on [DATE] with the diagnoses of chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF). Review of R83's Nursing Progress Notes located under the Progress Note tab in the EMR indicated on 07/31/25 at 5:08 AM the nurse documented, . Dipstick Result: Leukocytes: +1 . There were no signs and symptoms documented as the reason for the dipstick of R83's urine to be tested. Review of R83's Physician Orders located under the Orders tab in the EMR indicated an order dated 07/31/25 for Ciprofloxacin (an antibiotic) 250 milligrams (mg) one tablet every 12 hours for infection for three days. Review of R83's Medication Administration Record (MAR) dated July and August 2025 and provided by the facility, indicated on 07/31/25 at 8:00 PM, R83 did not receive the first dose of Ciprofloxacin 250 mg due to the medication not arrived from pharmacy. R83 received the antibiotic twice a day on 08/01 and 08/02 and only one dose on 08/03/25. Review of R83's Urine Culture provided by the facility and dated 08/02/25 indicated Usual skin flora > [greater than] 100,000 cfu/ml [colony forming unit/milliliter] 3 or more organisms isolated, culture doubtful significance, please recollect. There was no further documentation in the EMR's entirety to indicate another urine culture had been obtained. Review of the facility's Infection Control Surveillance Log dated February 2025 through February 2026 and provided by the facility indicated R83 did not meet McGeer's criteria for this infection. During an interview on 04/02/26 at 2:15 PM, the Infection Preventionist (IP) and [NAME] President of Clinical Services (VPCS) 1 met with the surveyor to review the antibiotic usage for infections. The IP confirmed R83 did not have nursing documentation of signs and symptoms to support the urine dipstick that was performed on 07/31/25, that a repeat urine culture had not been collected as instructed on the urine culture result dated 08/02/25, and the antibiotic was not administered for the three days that it was ordered to be given to R83. VPCS1 confirmed the nurses should have documented the signs and symptoms prior to obtaining the urine dipstick for R83. 2. Review of R33's admission Record located under the Profile tab in the EMR indicated R33 was readmitted to the facility on [DATE] with the diagnosis of heart failure. Review of R33's Nursing Progress Notes located under the Progress Note tab in the EMR and dated 08/03/25 at 6:05 PM indicated, Given verbal order from NP [nurse practitioner] to collect a UA [urinalysis] at 1600 [4:00 PM]. Resident did not have any urine output the rest of day shift ending at 1800 [6:00 PM]. Gave report to night shift nurse to continue verbal order. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R33's EMR in its entirety did not reveal any documentation of the urinalysis results that had been ordered on 08/03/25. There was also no documentation of a urine culture result. Review of R33's Physician Orders located under the Orders tab in the EMR and dated 08/07/25 revealed an order for Bactrim DS [an antibiotic] Tablet 800-160 milligrams give one tablet every 12 hours for bacterial infection UTI [urinary tract infection] for seven days. Review of R33's MAR located under the Orders tab in the EMR, and dated August 2025, indicated R33 received one dose of the antibiotic on 08/07/25 at 9:00 PM, from 08/08/25 through 08/13/25, R33 received doses of the antibiotic every 12 hours, and then one dose of the antibiotic was given on 08/14/25 at 9:00 AM. Review of the facility's Infection Control Surveillance Log dated February 2025 through February 2026 and provided by the facility indicated R33 did not meet McGeer's criteria for this infection. During an interview on 04/02/26 at 2:15 PM, the IP and VPCS1 confirmed that R33 did not have a urinalysis or urine culture obtained prior to the administration of antibiotics. They stated this should have been collected to see if there was a true UTI or not. 3. Review of R126's admission Record located under the Profile tab in the EMR indicated R126 was readmitted to the facility on [DATE] with the diagnosis of urinary tract infection. Review of R126's Nursing Progress Notes located under the Progress Note tab in the EMR and dated 02/15/25 at 5:48 PM indicated, . UTI finished IV [intravenous] antibiotics at hospital. On Zyvox (an antibiotic) for five days . Review of R126's Physician Orders located under the Orders tab in the EMR and dated 02/15/25 indicated an order for Zyvox 600 mg every 12 hours for UTI for five days. Review of R126's EMR in its entirety did not have documentation of a time out for the use of this antibiotic used for a UTI or urinalysis and culture results from the hospital to support the documentation of an UTI. Review of R126's MAR located under the Orders tab in the EMR, and dated February 2025, indicated R126 received this antibiotic for three days instead of the five days that had been ordered on 02/15/25. During an interview on 04/02/26 at 2:15 PM, the IP and VPCS1 confirmed that when R126 was readmitted to the facility after being in the hospital with a UTI, there had not been a time out to discuss with the medical provider whether the antibiotic needed to be continued after the completion of the IV antibiotic that was given in the hospital. The IP also confirmed there was no documentation by the medical provider that benefits of having the antibiotic continued outweighed the risk of this being completed. The VPCS1 returned to the conference room at 3:30 PM and stated that they could not find any further documentation for R83, R33, R126 for their documented antibiotic usage. 4. Review of the admission Record located in the Profile tab of the EMR revealed R85 was admitted to the facility on [DATE] with diagnoses that included paraplegia (paralysis of two limbs) and frequent (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	urinary tract infections. Review of the quarterly Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 12/31/25 revealed R85 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R85 was cognitively intact. The MDS indicated R85 had received an antibiotic during the seven-day observation period. Review of a Urinary Care Plan, revised 01/19/26, located in the Care Plan tab of the EMR revealed, R85 has a Urinary Tract Infection. There were no further updates to the Urinary Care Plan. Review of a Progress Note, dated 03/29/26, located in the Progress Notes tab of the EMR revealed, Approx [approximately] 0815 [8:15 AM] sent out to [hospital name] via [ambulance] due to fever, muscle aches, migraine, Nausea, feeling generally unwell and at the request of the resident provider and on call notified. Review of a Progress Note, dated 03/30/26, located in the Progress Notes tab of the EMR revealed, . Resident is alert and responsive. Able to make needs known. Resident has started Cefpodoxime Proxetil [an antibiotic] oral tablet 200 mg for UTI . During an interview on 04/01/26, the Infection Preventionist (IP) was asked if there had been an antibiotic time-out after R85 returned from the hospital and had she reviewed the urine culture to determine if the prescribed antibiotic was appropriate. The IP stated, Reports are pending. Lab cultures are usually sent to us. When we receive them, the admissions nurse will review it with the nurse from the hospital, and then she calls the physician and tells them what the order is and if they want to keep it or not. R85 has a lot of UTI's, and she did have a fever which was why she was sent to the hospital. During an interview on 04/02/26 at 3:30 PM, the IP provided the survey team with a copy of the urine culture report she had received which indicated mixed flora and therefore, would not have required an antibiotic. Review of the facility's policy Antibiotic Stewardship – Orders for Antibiotics, dated 01/09/26 indicated . Appropriate indications for use of antibiotics include: a. Criteria met for clinical definition of active infection or suspected sepsis; and b. Pathogen susceptibility, based on culture and sensitivity, to antimicrobial (or therapy begun while culture is pending). Empirical use of an antibiotic based on criteria of suspected sepsis may be appropriate. The staff and practitioner will document the specific criteria that support the suspicion in the resident's clinical record .

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure medication at the bedside was assessed for self-administration for 1 of 33 sampled residents (Resident (R) 60). This failure placed the resident at risk of receiving more medication than prescribed.Findings include:Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R60 was admitted to the facility on [DATE] with a diagnosis of allergic rhinitis (commonly known as hay fever or nasal allergies).Review of an 02/13/26 Physician Orders located in the Orders tab of the EMR revealed, Fluticasone Propionate Nasal Suspension (allergy nasal spray) 50 MCG [micrograms] 1 spray in both nostrils in the morning for Allergies.Review of the quarterly Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 03/12/26 revealed R60 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R60 was cognitively intact.During an observation and interview on 03/30/26 at 8:21 AM, R60 was observed to have a bottle of fluticasone nasal spray on her over bed table. R60 was asked if she administered the medication herself. She stated, Yes. R60 was asked if staff had assessed her to determine if she was capable of self-administration of the medication. R60 stated, I think I signed a form, but they don't watch me.Review of the Comprehensive Care Plan located in the Care Plan tab of the EMR did not show a focus/goal/intervention for the self-administration of the medication.During an interview on 03/30/26 at 10:50 AM, the Director of Nursing (DON) was asked if R60 had been assessed for self-administration of the Fluticasone nasal spray. The DON looked at the computer and stated there was not a self-administration form.During a follow-up interview on 03/31/26 at 1:52 PM, R60 was asked if she continued to self-administer the nasal spray. R60 stated, No, they whisked it away yesterday. R60 was asked how long she had had the medication on her over bed table. R60 stated, I think it was after I returned from the hospital last week.During a follow-up interview on 03/31/26 at 1:55 PM, the DON stated, Our process is we get an order from the physician, do an assessment to ensure safety, provide a lock box for the medication, update the care plan, and mark the eMAR [electronic medication administration record] to self-administration. The DON further stated, What was interesting is that the nurse on the floor had the medication in her cart and had administered the medication to her that morning. I do not know how she had her own bottle at the bedside.Review of the facility's policy titled, Self-Administration of Medications, dated 02/01/19 revealed, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the residents to do so.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of facility policy, the facility failed to ensure 1 of 33 sampled residents (Resident (R)114) was given the opportunity to make choices regarding his shower preference. This failure placed the resident at risk for a diminished quality of life.Findings include:Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R114 was admitted to the facility on [DATE] with a diagnosis of amyotrophic lateral sclerosis (ALS - a progressive neurodegenerative disease that destroys motor neurons in the brain and spinal cord), muscle weakness, and a need for assistance with personal cares.Review of the 02/06/26 Activity Interview for Daily Preferences located in the Assessments tab of the EMR, R114 was asked, How important is it to choose between a tub bath, shower, bed bath, or sponge bath. R114 responded, Somewhat important. R114 was asked, What type of bath do you prefer. R114 responded, Shower.Review of the admission Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 02/12/26 revealed R114 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R114's cognition was intact. R114 had range of motion impairment on both sides of his upper extremities and one side of his lower extremities and required substantial assistance with showering/bathing.Review of the 02/16/26 Activities of Daily Living [ADLs] Care Plan, located in the Care Plan tab of the EMR, revealed, [R114] has a Self-Care ADL [activities of daily living] performance deficit r/t [related to] Disease Process ALS. Interventions, dated 02/16/26 included, but were not limited to, Provide sponge bath when a full bath or shower cannot be tolerated, Bath/shower: resident will be offered bath/shower of choice on scheduled days and prn [as needed], The resident requires substantial/max [maximum][assistance] by (1) staff with bathing/showering as ordered, scheduled and as necessary.Review of the Tasks sheet, located in the Tasks tab of the EMR, revealed between 02/08/26 and 04/01/26, Certified Nurse Aides (CNAs) documented that R114 refused one shower/bed bath and received three partial bed baths, two full bed baths, and three showers.During an interview on 03/30/26 at 2:50 PM, R114 stated, I have been doing bed baths, but they are not as thorough. They use dry shampoo, but it would be nice to have my hair washed. R114 was asked what his preference was for bathing. R114 stated, A shower. I just recently found out they have a gurney shower bed, but they have not let me use it.During an interview on 03/31/26 at 2:30 PM, CNA7 stated, He [R114] has been physically tired and gets worn out. I am not sure why the change [to bed baths]. We do have a gurney for the showers, but they haven't been using it yet. I don't work on his bath days, but I do care for him on the other days. CNA7 was asked if R114 was not getting showers due to staffing issues. CNA7 stated, We are really struggling.During an interview on 04/01/26 at 10:30 AM, the Director of Nursing (DON) stated, If we have an extra aide, we utilize them as a shower aide, but I would love to have a shower aide all the time. I think there is more we can do about that. The DON confirmed that R114 had not been getting his preference of a shower consistently.Review of the facility's policy titled, Resident Rights, dated 02/01/19, revealed, The Resident has a right to make choices about aspects of his or her life in the Facility that are significant to the Resident.

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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, record review, and review of facility policy, the facility failed to develop a care plan related to activities for 1 of 3 residents (Residents (R) 114) reviewed for activities out of a total sample of 33 residents. This failure placed residents at risk for a diminished quality of life.Findings include:Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R114 was admitted to the facility on [DATE] with a diagnosis of amyotrophic lateral sclerosis (ALS-a fatal progressive neurodegenerative disease).Review of the Activities Initial Assessment, dated 02/09/26, located in the Assessments tab of the EMR revealed that R114 enjoyed bingo, social events, being outside, one-to-one visits, movies, using his iPad, and audiobooks.Review of the Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 02/12/26 revealed R114 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R114 was cognitively intact.Review of the 02/16/26 Comprehensive Care Plan located in the Care Plan tab of the EMR revealed no focus, goal, or interventions/approaches for activities.During an interview on 03/31/26 at 3:14 PM, the Activity Director (AD) stated, There should have been an Activity Care Plan developed. The AD further stated, [R114] still likes to get up in his wheelchair and go to therapy first thing in the morning and come to activities later.Review of the facility policy titled, Care Plans, Comprehensive, Person-Centered, dated 02/01/19 revealed, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident.

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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 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 observations, interviews, record review, and review of the facility policy, the facility failed to ensure the Comprehensive Care Plan was updated/revised for 3 of 33 sampled residents (Residents (R) 8, R56 and R68). The facility failed to update/revise the Behavior Care Plan to include resident specific interventions/approaches for R8 and R56. In addition, the facility failed to update/revise the care plan related to respiratory services for R68. These failures placed residents at risk for unmet care needs and a diminished quality of life.Findings include: 1. Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R8 was admitted to the facility on [DATE] with diagnoses that included cognitive communication deficit, adjustment disorder with mixed disturbance of emotions and conduct (a stress-related condition combining emotional distress (anxiety/depression) with behavioral issues.) Review of the Behavior Care Plan located in the Care Plan tab of the EMR revealed, R8 is demonstrating/has potential for verbally aggressive behaviors AEB [as evidenced by] using inappropriate language, racial slurs directed towards staff, accusatory towards staff, and yelling out r/t cognitive communication deficit, MDD [major depressive disorder], and other psychoactive substance abuse, in remission, revised 11/20/25. Interventions/Approaches included the following: Analyze of [sic] key times, places, circumstances, triggers, and what de-escalates behavior and document, dated 09/18/25. Assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain etc., dated 09/18/25. Cares in Pairs, dated 01/12/26. Review of the Comprehensive Care Plan located in the MDS tab of the EMR revealed, R8 is resistive to care AEB refusing medications, refusing brief changes, meds [medications], peri [perineal] care, meals, bathing, or being turned and adjusted r/t [related to] adjustment to nursing home, revised on 02/10/26. Interventions/Approaches included the following:Cares in Pairs, dated 01/12/26.Educate resident/family/caregivers of the possible outcome(s) of not complying with treatment or care, dated 09/16/25.Encourage as much participation/interaction by the resident as possible during care activities, dated 09/16/25 The Care Plans did not contain resident-specific interventions on how staff were to handle refusals or behaviors for R8. Review of the quarterly Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 03/16/26 revealed R8 had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated R8 was moderately impaired in cognition. The MDS indicated R8 had verbal behaviors and rejected care one to three days out of seven days during the observation period. Review of a Progress Note, dated 03/27/26, located in the Progress Notes tab of the EMR revealed, Resident refused to be changed with CNA [certified nursing aide] multiple times, Nurse went in and educated resident on importance of being changed. Resident allowed CNA to change her twice throughout the day shift. Resident's urine was strong with a foul odor each time the CNA changed her. Roommate made a complaint to staff of a bad smell coming from resident. Nurse offered Resident a bed bath or shower. Resident refused. (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 04/02/2026
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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an 03/29/26 IDT [interdisciplinary team] Note located in the Progress Notes tab of the EMR revealed, IDT team met to discuss this resident's yelling and cursing on 3/16 and 3/17/26. Will continue to follow the care plan. During an observation on 03/30/26 at 12:43 PM, R8 was observed lying in bed, covered with blankets. She answered some simple questions but did not want to continue the conversation. Her room had an overwhelming lingering body odor smell. During a follow-up observation on 04/01/26 at 10:55 PM, R8 was observed lying in bed covered with blankets. R8 was asked how she was feeling today. She stated, I am just tired. The body odor smell was gone. During an interview on 04/01/26 at 3:37 PM, the Director of Nursing (DON) stated, They [nursing staff] document in the progress notes her refusals, but the interventions/approaches are not in the Care Plan. There have been seven times she has refused psych services, but I see what you are saying, the interventions are not resident-specific. 2. Review of R56's admission Record, located under the Profile tab of the EMR, revealed he was originally admitted to the facility on [DATE] with diagnoses of paraplegia, muscle weakness, major depressive disorder, unspecified mood disorder, and anxiety. Review of R56's Care Plan Report, revealed a focus, revised 03/04/25, that R56 had a self-care activities of daily living (ADL) performance deficit due to activity intolerance and fatigue. Another focus, revised 03/04/25, revealed R56 had alterations in physical mobility due to impaired balance. An intervention was for staff to use a mechanical lift and two staff to transfer R56. A review of R56's annual MDS with an ARD of 03/07/26 and located under the MDS tab of the EMR, revealed R3's BIMS score was 15 out of 15, which indicated R56 had intact cognition. The MDS also indicated R56 was dependent on staff for mobility. During an interview on 04/01/26 at 4:46 PM, CNA9 stated R56 refused to get out of bed. She added he would request to get out of bed; she would get the mechanical lift, then he would change his mind. She stated she would ask again, and he would refuse. During an interview on 04/01/26 at 5:03 PM, CNA2 stated R56 would refuse to get out of bed. She said she referenced the care plan to see what the care needs were for each resident. CNA2 added she would expect the refusals to be care planned as R56 refused to get out of bed quite a bit. During an interview on 04/02/26 at 9:30 AM, the DON stated R56 refused to get out of bed often. She added that it should be care planned and that any nurse could add it to the care plan. 3. Review of R68's admission Record, located under the Profile tab in the EMR, revealed R68 was re-admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), hypertensive heart disease with heart failure, and functional quadriplegia (the complete inability to move due to severe physical disability or frailty, rather than direct brain or spinal cord injury). Review of R68's Care Plan Report, last revised 07/31/25, located under the Care Plan tab of the EMR, revealed a problem of resistive behaviors, [R68] is resistive to care AEB resisting ADL care, (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications . wearing oxygen . r/t unspecified sequelae of nontraumatic intracerebral hemorrhage, vascular dementia mild with other behavioral disturbance, depression. The care plan included generalized interventions such as education and negotiating care timing; however, it lacked individualized interventions specific to oxygen refusal. Review of R68's quarterly MDS, with an ARD of 11/10/25, located under the MDS tab of the EMR revealed a BIMS score of seven out of 15, which indicated moderate cognitive impairment. During an observation on 03/31/26 at 9:40 AM, R68 was in bed without the nasal cannula in place. Oxygen was running at two liters per minute via concentrator, with tubing placed approximately one foot away and out of reach. On 03/31/26 at 9:46 AM, Licensed Practical Nurse (LPN) 2 entered the room to administer medications and did not assess for, or reapply, the oxygen. During an interview on 03/31/26 at 10:15 AM, LPN2 stated R68 always removes the nasal cannula and was unable to identify how long the oxygen had been off. During observation on 04/01/26 at 9:18 AM, R68 was observed with the nasal cannula incorrectly positioned, with the prongs next to his nose. R68 acknowledged needing assistance for proper placement. LPN2 agreed to assist but could not state how long the oxygen had been worn improperly. Review of the facility policy titled, Care Plans, Comprehensive, Person-Centered, dated 02/01/19 revealed, . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . The comprehensive, person-centered care plan will: . Incorporate identified problem areas . Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision-making . When possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review and interview, the facility failed to initiate a care plan for heart failure, notify the physician of weight gain experienced in a five day period, follow and document the 1500 milliliter fluid restriction ordered, document why physician orders were not carried out by staff, and document a change in condition for one of one resident (Resident (R) 160) reviewed for congestive heart failure out of a total sample of 33 residents. Despite R160's diagnosis of congestive heart failure, recent six-pound weight gain in five days, and ordered fluid restriction, intravenous (IV) fluids were prescribed without documented reassessment of fluid status, intake/output monitoring, or evidence the order was carried out. These failures had the potential for R160 to experience fluid overload, decompensation, or the risk of rehospitalization.Findings include: Review of R160's admission Record located under the Profile tab in the electronic medical record (EMR) indicated R160 was admitted to the facility 03/21/26 with the diagnosis of NSTEMI (heart attack) and congestive heart failure (CHF) with bilateral pleural effusions. R160 also had a history of atrial fibrillation and chronic kidney disease stage III.Review of R160's hospital Discharge Summary located under the Misc tab in the EMR and dated 03/21/26 indicated that R160 had a thoracentesis [procedure used to remove excess fluid from the space between the lungs and chest wall] which resulted in 1.2 liters (L) of fluid drained from that site on 03/20/26. The discharge orders included for R160 to be on a 1500 milliliter (ml) daily fluid restriction.Review of R160's Social Service Note located under the Progress Note tab in the EMR and dated 03/24/26 at 1:27 PM indicated, BIMS [Brief Interview for Mental Status] completed by speech therapist on 3/23/26 with a score of three out of 15 indicating that this resident presents with severe cognitive impairment .1. Review of R160's admission Assessment located under the Assmnts tab in the EMR and dated 03/21/26 at 5:00 PM indicated that the resident had a primary diagnosis of heart failure for his most recent hospitalization. In response to, Have HF [heart failure] goals for treatment been established? the answer was No. In response to, If no, comments and plan to coordinate? there were no comments documented. Has HF care plan been initiated and reviewed? The answer was No.Review of the Baseline Care Plan provided by the facility, dated 03/23/26, indicated no documentation of CHF or of the 1500 ml fluid restriction.2. Review of R160's admission weight, dated 03/21/26, located under the Wts/Vitals tab in the EMR was documented as being 156 pounds hospital.Review of the Orders tab in the EMR revealed an order for weekly weights, dated 03/22/26. The order did not specify when to notify the provider of weight gain.Review of R160's Weight located under the Wts/Vitals tab in the EMR indicated on 03/26/26 the resident's weight was documented to be 162 pounds, which was a six-pound weight gain from the 156 pounds recorded five days earlier, on 03/21/26.Further review of R160's Progress Note tab in the EMR did not indicate the physician was notified of the six-pound weight gain in five days.During an interview on 03/31/26 at 2:17 PM, LPN3 stated that a six-pound weight gain in five days in a resident with CHF should be reported to the provider. 3. Review of the Orders tab in the EMR revealed an order for the 1500 ml fluid restriction dated 03/21/26 with no breakdown of how much fluid was able to be provided by nursing each shift and by dietary for each meal.Review of R160's Tasks tab of the EMR from 03/21/26 to 03/30/26 revealed the Certified Nursing Aides (CNAs) documented the amount of fluids they provided which R160 consumed each shift. There was no documentation of the fluids the nurses gave the resident during the medication passes. There was also no documentation of R160's output.During an interview on 03/31/26 at 2:45 PM, LPN6 was asked how the 1500 ml fluid restriction was divided between dietary and nursing. LPN6 stated she did not know and pulled up R160's EMR and began to read over the progress notes. LPN6 then stated, It looks like yesterday the dietician wrote that he was to have 1080 by dietary and 480 from nursing.4. Review of a Progress Note written by a provider, dated 03/29/26 at 3:14 PM and located under the Progress Note tab in the EMR, indicated, . patient seen for complaint of diarrhea . he was also receiving Lasix [diuretic medication], so he is likely be dry, he states he doesn't remember having diarrhea, poor historian, but feels fatigue and lethargic and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dehydrated, low urine output, dry lips, skin tenting . will rx [prescribe] fluids . Plan: Diarrhea, unspecified type: ongoing diarrhea x 2 days from taking abx [antibiotics] with severe dehydration and fatigue and lethargy, low urinary output rx IV fluids x 3 days. Will continue to monitor urine .Review of the Medication Administration Record (MAR), for March 2026, located under the Orders tab in the EMR, revealed the order for IV fluids, Dextrose Intravenous Solution 5 % (Dextrose) Use 1 liter intravenously one time only for 120/hr [120 ml per hour] . for 1 Day, start date 03/30/26, was pending confirmation. Review of R160's Progress Note tab of the EMR on 03/31/26 did not have documentation of the resident receiving any IV fluids that were ordered. Further review of the nursing progress notes for R160 did not reveal any documentation of why IV fluids were not started as ordered on 03/30/26 nor of the emergency contact being notified of the change in condition to warrant the use of IV fluids.During an interview on 03/31/26 at 2:17 PM, when asked why the provider had ordered the resident to have IV fluids, LPN3 stated, I really don't know. It happened after I left my shift. LPN3 reported R160 did not receive the IV fluids. The nurse told me in report that the resident refused to be stuck for the IV.5. During an observation on 03/30/25 at 12:25 PM, R160 was lying in his bed and could be heard coughing from the hallway. At 12:30 PM, Licensed Practical Nurse (LPN) 3 was observed in R160's room taking his vital signs. The nurse stated that he was not feeling well. LP3 left the room to get a new oximeter, and R160 stated, I have chest pain. Resident appeared to be lethargic and was short of breath with exertion or when talking. LPN3 returned to the room and stated to the resident that his oxygen saturation was 92 percent and that he did not have a temperature. She also stated to the resident that she had called the nurse practitioner, and she would be coming to see him. At 12:40 PM, the nurse practitioner was observed going into the resident's room to assess R160.Review of R160's Progress Note tab in the EMR on 03/31/26 at 9:00 AM revealed there was no documentation in the EMR for the nurses' vital signs that were taken or the reason LPN3 had stated to the resident that the NP would be coming to see him. There was no documentation by the NP of her visit on 03/30/26 at 12:40 PM.During an interview on 03/31/26 at 2:17 PM, LPN3 stated that on 03/30/26, The CNA had told me that [R160] was complaining of having chest pain, so I went into his room. I took his vital signs, and there was nothing alarming about them, so I reported this to the NP. When asked if she had documented the vital signs and report of chest pain in the EMR, LPN3 stated, I may not have. I was probably busy and didn't get to it. But I have 24 hours by state law to get this documented. When asked if a resident complaining of chest pain was considered a change in condition, LPN3 stated yes, but in his case, he has some dementia. LPN3 stated that she gave a detailed verbal report to the next shift of R160's condition. During an interview on 03/31/26 at 3:18 PM, the Director of Nursing (DON) confirmed that a resident having chest pain would be considered a change in condition and that a note should be documented in the chart as soon as possible. The DON also confirmed that the note should reflect what the resident was stating, the vital signs of the resident, the nurse's assessments at that time, the provider being notified, any orders that they may have received and the notification of the emergency contact of the resident. When asked about expectations for a resident with a diagnosis of CHF with a pleural effusion that required a thoracentesis prior to admission who had a six-pound weight gain over five days, the DON stated that the nurses come and tell her when a resident has a weight gain and then it is discussed in the risk meeting on the following Monday. Later in the interview, the DON confirmed that this would be too long to wait and the nurse should notify the physician of the weight gain. The DON also stated that she emphasized to the nursing staff that they needed to document any changes as soon as they occur because if it is not documented it is not done. During an interview on 04/02/26 at 12:50 PM, the NP stated that she assessed R160 on 03/30/26 because the nurse had reported to her that he was having chest pain. The NP explained that R160 did not express to her that he was having chest pain but rather was having abdominal discomfort, and R160's abdomen appeared to be distended. The NP ordered medication for the abdominal discomfort but stated she did not make a note on the assessment due to R160 being seen earlier that day by another provider, and her assessment didn't (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reveal a lot of difference from that assessment that was performed. The NP stated, looking back, it should have been documented. The NP continued to explain that the on-call provider ordered the IV fluids, and she was not aware of the reasoning of why the IV fluids were ordered. The NP was asked if a resident with a recent weight gain of six pounds over five days with no intervention should be getting IV fluids. She stated, I don't know if the nurses made the provider aware of this or not. I cannot speak to why the provider decided this, but it would be concerning that the IV fluids were ordered to be given. The NP stated she was not aware that a provider had not been notified of the weight gain over a five-day period, that the IV fluids had not been administered when ordered, that the nurses were not recording their intakes, and that outputs were not recorded, but these were important things that should have been taken care of or performed by the staff.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure oxygen and respiratory therapies were administered in accordance with physician orders and professional standards of practice. The facility also failed to ensure staff recognized and intervened when ordered respiratory treatments were not delivered effectively for 2 of 33 sampled residents (Resident (R) 68 and R138). This deficient practice placed residents at risk for low oxygen levels, ineffective treatment, respiratory compromise, infection, and impaired cognition.Findings include:1. Review of R68's admission Record, located under the Profile tab in the electronic medical record (EMR), revealed R68 was re-admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), hypertensive heart disease with heart failure, and functional quadriplegia (the complete inability to move due to severe physical disability or frailty, rather than direct brain or spinal cord injury).Review of Physician Orders located in the EMR under the Orders tab revealed R68 had an order for oxygen at four liters per minute continuously, dated 09/16/25.Review of R68's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/10/25, located under the MDS tab of the EMR revealed a Brief Interview for Mental Status (BIMS) score of seven out of 15, which indicated moderate cognitive impairment.Review of R68's Care Plan Report, located under the Care Plan tab of the EMR, revealed a problem of [R68] has oxygen therapy r/t [related to] CHF [congestive heart failure], Respiratory illness - emphysema, COPD, revised on 02/27/26, with an intervention, Oxygen Settings: O2 via nasal prongs as ordered continuously. Humidified, continuously.During an observation on 03/31/26 at 9:40 AM, R68 was observed in bed without the nasal cannula in place. The oxygen concentrator was set at two liters per minute, below the physician-ordered rate of four liters per minute. The oxygen tubing was out of the resident's reach.On 03/31/26 at 9:46 AM, Licensed Practical Nurse (LPN) 2 entered the resident's room to administer medications and did not assess oxygen use, ensure the nasal cannula was in place, or verify the oxygen was being delivered at the ordered rate.During an observation and interview on 03/31/26 at 10:15 AM, LPN2 stated the resident always removes the nasal cannula and was unable to identify how long the oxygen had not been in use. LPN2 confirmed the oxygen flow rate was set at two liters per minute and stated that R68 received oxygen at two liters per minute via nasal cannula continuously. LPN2 then reviewed R68's physicians orders and read aloud that the order was for four liters per minute.During a follow-up observation and interview on 04/01/26 at 9:18 AM, R68 was observed with the nasal cannula improperly positioned. The nasal cannula prongs were placed to the left side of the nose. R68 acknowledged the need for assistance by stating yes. LPN2 agreed to assist but could not state how long the oxygen had been worn improperly.During an interview on 04/01/26 at 1:03 PM, the DON stated that R68 always refused oxygen.2. Review of R138's admission Record, located under the Profile tab in the EMR, revealed R138 was re-admitted to the facility on [DATE] with diagnoses including acute respiratory failure with hypoxia and unspecified dementia.Review of Physician Orders, located in the EMR under the Orders tab, indicated R138 was prescribed nebulizer treatments on 07/26/25.Review of R138's Care Plan Report, located under the Care Plan tab of the EMR, revealed a problem of [R138] has COPD, revised on 08/12/25, that included a care plan intervention has history of SOB [shortness of breath] when lying flat, offer pillows/head of bed elevated.Review of R138's quarterly MDS, with an ARD of 01/26/26, located under the MDS tab of the EMR revealed a BIMS score of seven out of 15, which indicated moderate cognitive impairment.During an observation on 04/01/26 at 9:20 AM, R138 was receiving a nebulizer treatment while lying flat on her back in bed. The nebulizer medication chamber and tubing were resting on the resident's chest rather than positioned upright to allow for proper medication delivery. No staff were present to monitor the treatment. With continuous observation of the resident, the nurse did not return to check on the resident and nebulizer treatment until prompted by the surveyor at (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10:15 AM.During an observation on 04/01/26 at 10:15 AM, LPN1 turned off the nebulizer, wrapped the tubing around the machine, and placed it in the bedside drawer without cleaning the equipment.During interview on 04/01/26 at 11:30 AM, LPN1 stated the treatment had been initiated at 8:33 AM. The LPN acknowledged the resident should be positioned upright to ensure effective treatment and reduce risks such as impaired secretion clearance, aspiration, and respiratory distress. The LPN further acknowledged that failure to clean nebulizer equipment can lead to bacterial growth and increase the risk of respiratory infection.During interview on 04/02/26 at 9:51 AM, the Respiratory Therapist (RT) stated nurses may administer treatments; however, proper positioning, monitoring during treatment, and cleaning of equipment are necessary to ensure effectiveness and prevent complications. The RT stated failure to clean nebulizer equipment can result in contamination, reduced effectiveness, and increased risk of infections such as pneumonia or bronchitis.Review of the facility's policy titled, Respiratory Therapy Policy - Oxygen Use, dated 08/2024, indicated that respiratory therapists or clinical staff were responsible for ensuring oxygen was administered and delivered per physician's order and that respiratory equipment was properly maintained and sanitized.Review of facility training and competency records revealed nursing staff attended a skills fair that included respiratory therapy components; however, there was no documented evidence of competency validation specific to oxygen administration or nebulizer treatment techniques for LPN1 or LPN2.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and policy review, the facility failed to update physician orders and ensure medication labels accurately reflected the current route of administration of medication when a resident with a feeding tube began taking medications by mouth for 1 of 5 residents (Resident (R) 84) reviewed for medication administration out of a sample of 33 residents. This deficient practice placed the resident at risk for aspiration, ineffective medication delivery, and adverse outcomes related to improper route of administration.Findings include:Review of R84's admission Record, located under the Profile tab in the electronic medical record (EMR), revealed R84 admitted to the facility on [DATE] with diagnoses including aphasia following cerebral infarction and gastrostomy status.Review of R84's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/01/26, located under the MDS tab of the EMR revealed a Brief Interview for Mental Status (BIMS) score of zero out of 15, which indicated severe cognitive impairment. Review of the Medication Administration Record (MAR), dated 03/01/26 to 03/30/26, located under the Orders tab in the EMR, revealed that R84 had twelve medications scheduled to be administered by mouth and three medications scheduled to be administered by gastrostomy tube (G-tube). The three medications scheduled to be administered by G-tube included: docusate sodium (stool softener) 100 milligrams (mg) daily, hydralazine HCl (blood pressure medication) 100 mg twice daily, and atorvastatin (cholesterol lowering medication) 80 mg at bedtime. In addition, G-tube flushes were scheduled twice daily.During an observation on 03/31/26 at 10:07 AM, Licensed Practical Nurse (LPN) 2 administered medications to include the docusate sodium and hydralazine to R84 by mouth, mixed in pudding. The medication labels for the docusate sodium and hydralazine were observed to reflect the route of administration to be via G-tube.During an interview on 03/31/26 at 10:11 AM, LPN2 confirmed the physician orders and medication labels indicated administration via G-tube. LPN2 acknowledged administering the medications by mouth and stated that the R84 did not receive anything by G-tube. The G-tube was only flushed for patency. LPN2 stated nursing staff were responsible for ensuring medication orders and labels reflected the correct route of administration and for obtaining clarification from the physician when discrepancies were identified.During an interview on 04/01/26 at 1:07 PM, the Licensed Practical Nurse Unit Manager (LPNUM) 1 indicated that she was unaware that R84's medication orders and labels were inconsistent. LPNUM1 said that the nurses were responsible for following the medication rights when administering medications. LPNUM1 said that safe medication administration was ensured by validating orders before administration by checking the orders against the labels. LPNUM1 said that a pharmacy consultant conducted cart audits for compliance; however, she was also responsible to periodically ensure medications were labeled and managed in a manner that supported safe administration.Review of the facility's policy titled, Liberalized Medication Administration - Policy & Procedure, dated 02/2023, indicated that nursing staff are required to follow the Five Rights of Medication Administration, including the right route, when administering medications.Review of the facility's policy titled, Storage of Medications dated 02/01/19, indicated that medications with missing, incomplete, or incorrect labels must be returned to the pharmacy for proper labeling prior to use.