STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hearthstone	1950 Baring Blvd Sparks, NV 89434

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of facility's policy, the facility failed to ensure 4 of 5 residents (Resident (R) 1, R35, R90 and R97) reviewed for hospitalization out of 31 sampled residents were given a bed hold notice prior to or within 24-hours of emergency transfer to the hospital and/or failed to ensure the Ombudsman was notified of the emergent transfers to the hospital. This failure creates the potential for residents, and responsible parties to not have the information needed to safeguard their return to the facility, and for the Ombudsman not to have the knowledge of their transfer. Findings include: 1. Review of R35's Face Sheet located under the Profile tab of the electronic medical record (EMR) revealed R35 was admitted to the facility on [DATE]. Review of R35's Progress Note, dated 02/26/2026 and located under the Progress Notes tab of the EMR revealed R35 was sent to the hospital for vaginal bleeding. Review of R35's entire medical record revealed no documented evidence that the facility issued a bed hold notice to R35 and/or their responsible party at the time of the transfer or the day after. Further review indicated no documented evidence that the Ombudsman was notified of R35's transfer to the hospital on [DATE]. 2. Review of R90's Face Sheet located under the Profile tab of the EMR revealed R90 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of R90's Progress Note, dated 12/27/2025 and located under the Progress Notes tab of the EMR revealed R90 was sent to the hospital from the dialysis center due to increased chills and shivering. Review of R90's entire medical record revealed no documented evidence that the facility issued a bed hold notice to R90 and/or R90's responsible party at the time of the transfer or the day after. Further review revealed no documented evidence that the Ombudsman was notified of R90's transfer to the hospital on [DATE]. 3. Review of R97's Face Sheet located under the Profile tab of the EMR revealed R97 was re-admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD). Review of R97's Progress Note, dated 12/19/2025 and located under the Progress Notes tab of the EMR revealed R97 was sent to the hospital for COPD exacerbation. Review of R97's entire medical record revealed no documented evidence that the facility issued a bed hold notice to R97 and/or R97's responsible party at the time of the transfer or the next day. Further review revealed no documented evidence that the Ombudsman was notified of R97's transfer to the hospital. During an interview on 03/04/2026 at 12:00 PM, the Administrator indicated that R35, R90, and R97 and/or their responsible parties were not issued a written bed hold notice when they were emergently transferred to the hospital. 4. Review of R1's undated Face Sheet, located under the Profile tab in the EMR indicated R1 was admitted to the facility on [DATE].Review of R1's Progress Note, dated 01/27/2026 at 4:30 PM and located under the Prog Notes tab in the EMR indicated R1 had been transferred to the ER to rule out a subdural hematoma after he fell and hit his head. Further review revealed no documented evidence that the Ombudsman was notified of the resident's emergent transfer to the hospital. During a subsequent interview on 03/04/2026 at 3:58 PM, the Administrator indicated that the Ombudsman was not made aware of R1, R35, R90, nor R97's emergent transfers to the hospital.Review of the facility's policy titled, Criteria for Transfer and Discharge, revised April 2025, indicated Prior to transfer or discharge, (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the Facility shall notify the resident and the resident's representative of the transfer or discharge and the reason for the transfer or discharge in writing in a language and manner they understand. The facility shall send a copy of the notice to the State Long-Term Care Ombudsman.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, facility policy review, and review of the facility's investigations, the facility failed to ensure 2 residents (Resident (R) 9 and R120) of 4 residents reviewed for abuse out of 31 sampled residents were free from verbal abuse. R120 was verbally abused by her roommate (R119), and R9 was verbally abused by Certified Nursing Assistant (CNA) 9. The facility's failure to ensure residents were free from abuse had the potential to cause emotional and/or psychosocial harm to the residents. Findings include:1. Review of R120's Face Sheet found in R120's electronic medical record (EMR) under the Resident tab indicated the resident was admitted to the facility on [DATE] with diagnoses which included cognitive communication deficit, anxiety disorder, and unspecified dementia.Review of R120's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/15/2025 and located under the MDS tab of the EMR indicated the resident had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated the resident was severely cognitively impaired. Review of R120's nursing Progress Notes, dated 10/06/2025 and located in the residents EMR under the Prog [progress] Notes tab indicated, Patient reported her roommate tv is too loud.When this patient turned on her tv, the roommate began yelling and cursing at this patient to turn her f****** [explicit] tv down. This patient stated she was afraid to go back into the room.No observations or interviews could be made of R120 as this resident had been discharged from the facility on 10/26/2025.Review of R119's Face Sheet found in R119's EMR under the Resident tab indicated the resident was admitted to the facility on [DATE] with diagnoses which included cognitive communication deficit and altered mental status.Review of R119's admission MDS with an ARD of 10/07/2025 and located under the MDS tab of the EMR indicated the resident had a BIMS score of 13 out of 15 which indicated the resident was cognitively intact. The assessment revealed the resident had no behaviors directed towards others.Review of R119's nursing Progress Notes, dated 10/06/2025 and located under the Prog tab revealed Reported by nursing staff that resident [R119] was heard yelling at her roommate [R120] Shut the f****** [explicit] TV off.No observations or interviews could be made of R119 as this resident had been discharged from the facility on 10/17/2025.Review of a Facility Incident Report dated 10/06/2025 and provided by the facility indicated Type of Incident-Verbal Abuse. Details of Incident-Per report by [name of Registered Nurse (RN)1] patients were in dispute over volume of TVs. [name of R120] entered the room and asked [name of R119] to turn her tv down to which R119 began yelling profanities to R120 calling her a f***ing [explicit] liar and telling her to get out of the room or she would have her ass. The incident report further indicated, Patients were separated and remain safe in the facility at this time. The incident report indicated, No injuries noted but patient [identified as R120] felt scared to go back into her room while the other patient was there.Review of an undated written statement from RN1 as part of the facility's investigation, indicated, So [name of R120] complained that the B bed [name of R119] TV was too loud. So, I got a headset and put in on [name of R119]. [name of R120] went back in the room, turned her TV on and [name of R119] started screaming Shut the F**** [explicit] TV off. [Name of R120] came out of the room and said anytime she goes in the room, the roommate cusses her out.Review of an undated statement from R120 regarding the incident indicated, I went to watch TV and she [referring to R119] yelled at me to turn my f'n [sic] tv down and told me if I don't, she's going to get my ass.During an interview on 03/04/2026 at 2:25 PM, the Director of Nursing (DON) stated that she was new at the time of this incident and was being trained by the previous DON on this incident of verbal abuse that occurred between R119 and R120. The DON stated, I vaguely remember the situation where [name of R119 and R120] were roommates and [name of R120] had gone in the room and [name of 119] started cussing and yelling at [name of 120] about the tv. [name of RN1] came and told me about it and the residents were separated. The DON then stated, As a (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	result of the investigation, I believe we substantiated it as a type of verbal abuse. Yes.During an interview on 03/04/2026 at 3:56 PM, the Administrator stated, In reviewing this allegation, we determined it was an allegation of verbal abuse. Yes.2. Review of R9's Face Sheet, located under the Profile tab of the EMR revealed R9 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of R9's annual Minimum Data Set (MDS), with an ARD of 01/16/2026 and located under the MDS tab of the EMR revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R9 was cognitively intact. The annual MDS indicated R9 was dependent on staff for incontinent care.Review of the Facility Reported Incident (FRI) investigation dated 12/24/2025 and provided by the facility revealed R9 was subjected to verbal abuse by a Certified Nursing Assistant (CNA 9). The Administrator reported that he was informed that a CNA yelled at resident [R9]. After interviewing [R9], she stated that she had not been changed timely. [The] Facility completed [an] investigation, and it was found that [CNA9] was involved in verbal alt (altercation) with [the] resident. The facility cannot determine that the CNA [CNA9] completed timely rounds. [CNA9] was terminated on completion of [the] investigation. [R9] states she feels safe an [sic] the facility at this tjme [sic]. The report noted that the accused staff member, (CNA9), was immediately placed on leave and terminated following the substantiation of the abuse. During an interview on 03/03/2026 at 9:40 AM, R9 recalled the incident and stated, She [CNA9] was very mean, yelled at me, wouldn't change me. She doesn't work here anymore, thank goodness.During an interview on 03/05/2026 at 9:00 AM, CNA8 who witnessed the verbal abuse repeated her witness statement confirming the verbal abuse of R9. CNA8 stated she heard yelling/screaming, walked around and found CNA9 coming out of R9's room screaming at her. The resident stated she had not been changed, that CNA9 was making excuses not to change her, and yelled at her. CNA8 observed CNA9 continue to yell at the resident and state, I'm not the type to be messed with and that CNA9 would make the resident's life a living hell. CNA8 immediately reported the incident to the charge nurse and the staff scheduler.During an interview on 03/05/2026 at 11:22 AM, the Administrator stated the investigation was substantiated, the CNA (CNA9) was terminated, and the Board of Nursing was notified.Review of the facility's policy titled Abuse: Prevention of and Prohibition Against, revised 08/2025 indicated, It is the policy of this facility that each resident has the right to be free from abuse.The facility will provide oversight and monitoring to ensure that its staff, who are agents of the facility, deliver care and services in a way that promotes and respects the rights of the residents to be from abuse. It further indicated, Verbal Abuse includes the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their representatives.regardless of their age, ability to comprehend, or disability. The policy indicated, Protection-If an allegation of abuse is reported, discovered or suspected, the facility will take the following steps to protect all residents from physical and psychosocial harm during and after the investigation.If the allegation of abuse involves another resident, the facility will: Separate the residents so they do not interact with each other until circumstances of the reported incident can be determined.a room change if appropriate.continue to assess, monitor and intervene as necessary to maximize resident health and safety.Cross reference with F609 and F610

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to report substantiated verbal abuse to local law enforcement for 2 of 4 residents reviewed for abuse (Resident (R) 9 and R120) out of 31 sampled residents. Certified Nursing Assistant (CNA) 9 verbally abused R9 by making intimidating and threatening statements to the resident and R120 was verbally abused by another resident; however, the facility did not identify the abuse as a possible crime and report it to local law enforcement. This failure left the residents being victims of abuse without proper investigation from law enforcement. Findings include: 1. Review of R9's Face Sheet, located under the Profile tab in the Electronic Medical Record (EMR) revealed R9 was admitted to the facility on [DATE]. and readmitted on [DATE]. Review of R9's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/16/2026 and located under the MDS tab in the EMR revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R9 was cognitively intact. The annual MDS also indicated R9 was dependent on staff for incontinent care.Review of the Facility Reported Incident (FRI) investigation, dated 12/24/2025 and provided by the Administrator revealed the facility substantiated that R9 was verbally abused by CNA9. During an interview on 03/03/2026 at 9:40 AM, R9 recalled the incident and stated, She (CNA9) was very mean, yelled at me, wouldn't change me. She doesn't work here anymore, thank goodness. When asked how the CNA's statements made her feel, the question triggered an event that happened historically involving a sheriff's deputy. R9 kept repeating the historic incident. During an interview on 03/05/2026 at 9:00 AM, CNA8 stated she witnessed CNA9 verbally abusing R9. Continued interview revealed CNA8 witnessed CNA9 making intimidating and threatening statements to R9.During an interview on 03/05/2026 at 11:22 AM, when asked if the Police Department had been notified, the Administrator stated, No, for verbal abuse. We determine if a crime has been committed before we notify the police. When asked how that determination was made, no information was provided. When asked how he viewed CNA9's statement of I'm not the type to be messed with and that CNA9 would make the resident's life a living hell, the Administrator said he viewed the statement as a threat. 2. Review of R120's Face Sheet found in R120's electronic medical record (EMR) under the Resident tab indicated the resident was admitted to the facility on [DATE].Review of R119's Face Sheet found in R119's EMR under the Resident tab indicated the resident was admitted to the facility on [DATE].Review of a Facility Incident Report dated 10/06/2025 and provided by the facility indicated Type of Incident-Verbal Abuse.R119 began yelling profanities to R120 calling her a f****** [explicit] liar and telling her to get out of the room or she would have her ass. The incident report further indicated, .patient [identified as R120] felt scared to go back into her room while the other patient was there.Review of the facility's investigation file dated 10/10/2025 and provided by the facility for the abuse incident involving R119 and R120 revealed no documented evidence the abuse was reported to local law enforcement.During an interview on 03/04/2026 at 2:25 PM, the Director of Nursing (DON) When asked if there was documentation Law Enforcement was notified, the DON stated, No, I don't see they were notified.During an interview on 03/04/2026 at 3:56 PM, when asked if there was documentation that Law Enforcement was notified regarding the facility's investigation of R120 being verbally abused, the Administrator stated, No. We have decided if we felt it was a crime then we would involve them. But no, they were not notified.Review of the facility's policy titled Abuse: Prevention of and Prohibition Against, dated 12/2023 revealed Allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the facility and to the appropriate State or Federal agencies in the applicable timeframes as per this policy and applicable regulations.Cross reference with F600 and F610

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, review of the facility's policy, and review of the facility incident reports and investigations, the facility failed to complete thorough investigations of allegations of abuse and neglect for 3 of 4 residents reviewed for abuse (Resident (R) 14, R68, and R120) out of 31 sampled residents. The facility's failure to complete thorough investigations placed residents at risk of being unprotected from abuse. Findings include:1. Review of R120's Face Sheet found in R120's electronic medical record (EMR) under the Resident tab indicated the resident was admitted to the facility on [DATE].Review of R120's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/15/2025 and located under the MDS tab of the EMR indicated the resident had a Brief Interview for Mental Status (BIMS) score of six out of 15 which indicated the resident was severely cognitively impaired.Review of R119's Face Sheet found in R119's EMR under the Resident tab indicated the resident was admitted to the facility on [DATE].Review of R119's admission MDS with an ARD of 10/07/2025 and located under the MDS tab of the EMR indicated the resident had a BIMS score of 13 out of 15 which indicated the resident was cognitively intact. The assessment revealed the resident had no behaviors directed towards others.Review of a Facility Incident Report dated 10/06/2025 and provided by the facility indicated Type of Incident-Verbal Abuse.Details of Incident-Per report by [name of Registered Nurse (RN) 1] patients were in dispute over volume of TVs. [name of R120] entered the room and asked [name of R119] to turn her tv down to which R119 began yelling profanities to R120 calling her a f****** [explicit] liar and telling her to get out of the room or she would have her ass. The incident report further indicated, Patients were separated and remain safe in the facility at this time. The incident report indicated, No injuries noted but patient [identified as R120] felt scared to go back into her room while the other patient was there.Review of the facility's investigation file dated 10/10/2025 and provided by the facility for the abuse incident involving R119 and R120 indicated Investigation completed. Based on employee witness statements it appears [name of R119] did tell [name of R120] to Turn the [explicit tv down or she would have her ass. However, staff intervened right away. They were separated and redirected the residents as [name of R119] was moved to a different room. No negative adverse effects noted pertaining to this incident. The facility investigation did not indicate which staff intervened, and the investigation file only contained an undated statement from Registered Nurse (RN) 1 with no date indicated in the statement. There was no evidence additional staff or residents were interviewed regarding this incident. The facility investigation only contained one undated statement from RN1, an interview with R120 with no date/time or who interviewed R120 and no statement from R119.Review of an untitled and undated statement from RN1 as part of the facility investigation, indicated, So [name of R120] complained that the B bed [name of R119] TV was too loud. So, I got a headset and put in on [name of R119]. [name of R120] went back in the room, turned her TV on and [name of R119] started screaming Shut the F**** TV off. [Name of R120] came out of the room and said anytime she goes in the room, the roommate cusses her out. [Name of R120] said she was scared to go into her room.Review of an untitled and undated statement from R120 regarding the incident indicated, I went to watch TV and she [referring to R119] yelled at me to turn my f'n [sic] tv down and told me if I don't, she's going to get my ass. And then [name of previous Social Services Director] came and offered headphones to her and then she started saying to me Your nothing but a f'n [sic] liar and you went and told her to make me put these on.Review of the same untitled and undated document indicated, [name of R119] denies anything occurring. There was no evidence of any other written statements from the previous social services director, no additional staff, or residents.Review of R120's nursing Progress Notes, dated 10/06/2025 and located in the residents EMR under the Prog [progress] Notes tab indicated, Patient reported her roommate tv is too loud.When this patient turned on her tv, the roommate began yelling and cursing at this (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	patient to turn her fucking tv down. This patient stated she was afraid to go back into the room.No observations or interviews could be made of R120 as this resident had been discharged from the facility on 10/26/2025.Review of R119's nursing Progress Notes, dated 10/06/25 and located under the Prog [prognosis] tab revealed Reported by nursing staff that resident [R119] was heard yelling at her roommate [R120] Shut the fucking TV off.No observations or interviews could be made of R119 as this resident had been discharged from the facility on 10/17/2025.An unsuccessful attempt to contact RN1 via phone was made on 03/04/2026 at 2:17 PM. During an interview on 03/04/2026 at 2:25 PM, the Director of Nursing (DON) stated, We would have gotten statements from anyone that was there, witnesses, or anyone that was involved but I see the report is incomplete. When reviewing the facility investigation file with the DON, she confirmed there was no statement from R119, no documentation from the previous social services director, no statement from the previous DON, no statements from any staff that were present at the time of the incident and no interviews/statements from additional residents that may have heard the incident. During an interview on 03/04/2026 at 3:56 PM, regarding the facility investigation of verbal abuse, the Administrator stated, In reviewing this allegation, we determined it was an allegation of verbal abuse. Yes. When reviewing the facility investigation file with the Administrator he stated, I do not see a date or time of the statement taken from [name of RN 1]. I have no idea of when the statement was given. He stated, I see [name of 119] was talked to but I don't see who interviewed her or a date or time and I'm not seeing a statement from [name of R120]. He further stated, I'm not sure when or who spoke to [name of 119] and I do not see any further statements from any other staff or residents here. When the Administrator was asked if he thought the investigation was complete, he stated, Based on what I see in the file. I would agree it's not a complete and thorough investigation. We are missing documentation to show interviews from staff were completed and any residents if they heard anything.2. Review of R68's Face Sheet found in R68's EMR under the Resident tab indicated R68 was admitted to the facility on [DATE] with diagnoses to include acute respiratory failure, cognitive communication deficit, and anxiety disorder.Review of R68's admission MDS with an ARD of 01/13/2026 and located under the MDS tab in the EMR indicated the resident had a BIMS score of five out of 15 which indicated the resident was severely cognitively impaired.Review of a Facility Incident Report regarding R68 dated 02/05/2026 indicated Type of Incident-Neglect. The incident report indicated On 02/05/26 at approximately 14:15 [2:15 pm], the incident occurred in room [R68's room number] .The resident was last seen leaving the facility in a wheelchair with a visitor.without notifying nursing staff.staff learned from the roommate that a woman had wheeled him out of the facility. The facility indicated the allegation was verified. The facility investigation further indicated, The facility initiated an internal investigation immediately upon discovery of the incident on 02/05/26. Interviews were conducted with involved staff, including nursing staff who observed the resident's absence, the DON, and the resident [identified as R68]. Staff also obtained information from the resident's roommate who reported that a woman packed the resident's belongings and wheeled him out of the facility.Review of R68's Social Services notes dated 02/05/2026 and located in the resident's EMR under the Prog [progress] Notes tab indicated, Notified that the pt. [patient] was taken out of the facility, however the individual who removed the pt. [patient] is unknown.Review of R68's nursing Progress Notes, dated 02/05/2026 and located in the resident's EMR under the Prog [progress] Notes tab indicated, This DON [Director of Nursing] was notified that the resident was no longer in his room and that the roommate had said a woman came and gathered his belongings and wheeled him out.During an observation and interview of R68 on 03/02/2026 at 1:45 PM, R68 was observed in his room laying in bed. He was observed to be alert and oriented. During an interview regarding the incident that occurred on 02/05/2026, R68 stated, I left for a day and a half then I came back. I left to a friend's house. At the time, my room was going to get painted and the next day my friend came to get me. I tried to see if anyone was around at the nurse's station to let them know but couldn't find anybody so I got in the car and left.During an interview on 03/02/2026 at 2:00 PM, Licensed Practical Nurse (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(LPN) 4 stated, That day of the incident I recall he [referring to R68] had a visitor. I didn't know she was going to take him .LPN4 stated, The CNA went into the room to answer the call light and saw he [R68] was gone then came to get me. I immediately went to the Administrator and the DON, and we called a Code Orange [missing resident. When LPN4 was asked if she was asked to write a written statement as part of the facility investigation she stated, No.During an interview on 03/02/2026 at 2:45 PM, regarding the facility investigation of R68, the Receptionist (REC) stated she recalled a visitor who came to see R68 on 02/05/26 and signed her name on the sign-in log. The receptionist then stated, she also recalled seeing R68 leave with the visitor out the front entrance and recalled seeing the same visitor return R68 the following day. When asked if she was asked to write a statement as to being a witness to seeing R68 leave the facility on 02/05/26, the receptionist stated, No.During an interview regarding the facility investigation on 03/03/2026 at 1:50 PM, the DON was asked if there was any documentation of staff interviewing R68's roommate as part of the investigation, she stated, No. During an interview and review of the facility's investigation file on 03/03/2026 at 3:26 PM, when the Administrator was asked if there was any evidence of documented statements from R68, R68's roommate, LPN4, additional staff that worked on 02/05/26 to include any CNAs, any other residents on the unit, the former DON, ADON, the former social services director, and the front receptionist, the Administrator stated, No. We did not get statements. 3. Review of R14's Face Sheet located under the Profile tab of the (EMR) revealed R14 was admitted to the facility on [DATE]. Review of R14's quarterly MDS with an ARD of 01/19/2026 and located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. Review of the facility's final investigation report dated 01/18/2026, revealed R14 reported It was alleged that a CNA named [first name] told the resident to shut up and that she did not change her. It was reported that it was 'a couple of weeks ago.' . The initial allegation was reported on 01/13/2026.Review of the facility's investigation folder revealed interviews/statements were obtained from four other residents, one CNA, and a nurse. There was no written interview/statement from R14 in the folder. The facility's investigation revealed no documented evidence of other CNAs named [first name] were identified and interviewed who worked at the facility. The nursing schedules included were dated 01/10/2026 through 01/15/2026 and only included first names.Review of the facility's employee roster revealed there were six staff members named [first name] or similar. During an interview on 03/04/2026 at 3:09 PM, the Director of Nursing (DON) stated, I was the ADON [Assistant Director of Nursing] at the time. I interviewed [R14]. [R14] reported the CNA went in her room and [R14] needed a brief change. The CNA yelled at her. [R14] said the CNA's name was [first name] and described the CNA as younger with shorter light-colored hair. [R14] did not have a specific date but 2 weeks prior and occurred during mid-day. I interviewed the staff person that fit the description as [CNA7]. We didn't talk to other CNAs. Administration was out of town at the time of the allegation. When asked about the staffing schedules being reviewed for only four days prior and not during the time frame the resident alleged, the DON did not respond with a comment. During an interview on 03/04/2026 at 4:14 PM, the Administrator stated the facility's investigation of R14's allegation was not a complete investigation. The Administrator also stated he would have expected to see two weeks of staff schedules reviewed, would have expected all staff with [first name] to be interviewed, and would have expected other staff to be interviewed.Review of the facility's policy titled, Abuse: Prevention of and Prohibition Against revised 08/2025 indicated It is the policy of this facility that each resident has the right to be free from abuse, neglect. It further indicated Definitions: Neglect is the failure of the facility.to provide goods and services to a resident that are necessary to avoid physical harm, mental anguish, or emotional distress.Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but the facility failed to provide them.Neglect includes cases where the facility's indifference or disregard for resident care, comfort, of safety resulted in or could have resulted in, physical harm, mental anguish, or emotional (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	distress. The policy indicated, Verbal Abuse includes the use of oral, written, or gestures language that willfully includes disparaging and derogatory terms to residents.regardless of their age, ability to comprehend, or disability. The policy indicated, Investigation- all identified events are reported to the Administrator immediately.all allegations of abuse, neglect.will be promptly and thoroughly investigated by the Administrator or his/her designee.The investigation will include the following: An interview with the person(s) reporting the incident; an interview with the resident(s); interviews with any witnesses to the incident, including alleged perpetrator, as appropriate; an interview with staff members (on all shifts) who may have information regarding the alleged incident; interviews with other residents to whom the accused employee provides care or services or may have information surrounding the incident.At the conclusion of the investigation, the facility will attempt to determine if abuse, neglect.has occurred. The investigation, and the results of the investigation, will be documented. The policy indicated, Allegations of abuse, neglect.will be reported outside the facility and to the appropriate State or Federal agencies.Cross reference with F600 and F609

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews, review of the Resident Assessment Instrument (RAI) Manual, and facility policy review, the facility failed to ensure the Minimum Data Set (MDS) assessments were completed accurately for 3 of 31 sampled residents (Resident (R) 10, R48, and R97). Staff failed to accurately code hospice for R10; failed to accurately code a multidrug-resistant bacteria (MDRO) infection for R48; and failed to accurately code intravenous (IV) feeding for R97. Failure to code the MDS correctly can lead to inaccurate federal reimbursement and inaccurate assessment and care planning for the residents. Findings include: 1. Review of R97's Face Sheet located under the Profile tab of the electronic medical record (EMR) revealed R97 was re-admitted to the facility on [DATE]. Review of R97's quarterly MDS, with an Assessment Reference Date (ARD) of 12/26/2025, located under the MDS tab of the EMR indicated, .Parenteral/IV feeding [as a yes] while a resident.Review of R97's physician Order Summary Report, dated 03/04/2026 and located under the Orders, tab of the EMR indicated no evidence of a physician's order for Parenteral/IV feedings. Review of R97's Medication Administration Record (MAR), dated December 2025 and located under the Orders, tab in the EMR indicated no evidence of an order to administer Parenteral/IV feedings. During an interview on 03/04/2026 at 4:10 PM, the MDS Director (MDSD) confirmed that R97 received IV feedings while in the hospital, not at the facility. The MDSD stated R97's quarterly MDS was miscoded, which indicated it was not accurately completed.2. Review of R10's Face Sheet located under the Profile tab of the EMR indicated the resident was admitted to the facility on [DATE] with diagnoses which included encounter for palliative care.Review of R10's physician's Order, dated 07/15/2025 and located under the Orders tab of the EMR, revealed R10 had an order for hospice services. Review of R10's quarterly MDS, with an ARD of 01/22/2026 and located under the MDS tab indicated the response to Hospice Care was not checked.During an interview on 03/05/2026 at 2:05 PM, the MDS Director (MDSD) stated [R10] was admitted to hospice services on 07/17/2025. The MDSD confirmed the MDS with an ARD of 01/22/2026 was marked No for hospice services. The MDSD also stated that it was marked No in error and should have been marked yes.3. Review of R48's Face Sheet located under the Profile tab of the EMR indicated the resident was admitted to the facility on [DATE] with diagnoses which includedextended spectrum beta lactamase (ESBL) resistance. Review of R48's quarterly MDS, with an ARD of 01/08/2026 and located under the MDS tab indicated the response to: Active Diagnoses in the last 7 days had Multidrug-Resistant Organism (MDRO) marked.Review of R48's physician Order, dated 05/07/2025 and located under the Orders tab of the EMR, revealed an order for Transmission Based Precautions for ESBL in urine. The order was discontinued on 05/10/2025. During an interview on 03/05/2026 at 2:58 PM, the Infection Preventionist (IP) stated R48 had a history of MDRO from the ESBL infection when she was admitted but did not have an infection in January 2026 during her MDS assessment. The IP stated the MDS was marked in error since R48 did not have an active infection at the time. During an interview on 03/05/2026 at 2:05 PM, the MDSD stated R48's MDS was marked in error on 01/08/2026 since she did not have an active infection during the review period.Review of the facility's policy titled, MDS Completion, Resident Assessment, dated February 2020, indicated, It is the policy of this facility to complete accurate and timely MDS assessments in accordance with Federal and State requirements. IDT [interdisciplinary team] Members Attest to accuracy of each item they are coding by signing each item for completion.Review of the Long-term Care Facility Resident Assessment Instrument 3.0 User's Manual, revised October 2025, revealed .the intent of this section is to identify any special treatments, procedures, and programs that the resident received or performed during the specified time periods.revealed the intent of this section is to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	picture of the resident's current health status.the intent of this section is to assess the many conditions that could affect the resident's ability to maintain adequate nutrition and hydration. This section covers swallowing disorders, height and weight, weight loss, and nutritional approaches. The assessor should collaborate with the dietary staff to ensure that items in this section have been assessed and calculated accurately.It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy [what the resident's actual status was during that observation period] by the IDT [Interdisciplinary] completing the assessment .

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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 record review, interview, and policy review, the facility failed to develop person centered care plans based on residents' comprehensive assessments for 2 of 31 sampled residents (Resident (R) 14 and R27). This failure placed the residents at risk of unmet care needs.Findings include:1. Review of R14's Face Sheet located under the Profile tab in the Electronic Medical Record (EMR) revealed the resident was admitted to the facility on [DATE] with diagnoses which included generalized muscle weakness, cognitive communication deficit, and major depressive disorder.Review of R14's quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) 01/19/2026 and located under the MDS tab in the electronic medical record (EMR) revealed R14 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated she was cognitively intact. The assessment also indicated that R14 was dependent on staff for toileting and was incontinent of bowel and bladder.Review of R14's Documentation Survey Report dated December 2025 and January 2026, located under the Reports tab of the EMR, revealed R14 was incontinent of bowel and bladder.Review of R14's Care Plan located under the Care Plan tab of the EMR revealed there was not a care plan that indicated R14 was incontinent of bowel and bladder.During an interview on 03/05/2026 at 4:32 PM, the Director of Nursing (DON) confirmed urinary and bowel incontinence were not included on R14's care plan and stated urinary and bowel incontinence should have been care planned. 2. Review of R27's Face Sheet located under the Profile tab in the EMR revealed the resident was admitted on [DATE] with diagnoses which included complete loss of teeth, cognitive communication deficit, generalized muscle weakness, dementia, and generalized anxiety disorder.Review of R27's annual MDS with an ARD of 02/13/2026, located under the MDS tab in the EMR revealed a BIMS score of 14 out of 15 which indicated R27 was cognitively intact. The assessment also revealed that R27 required assistance with oral hygiene and bathing. Review of R27's Care Plan located under the Care Plan tab of the EMR revealed there was not a care plan that indicated R27 needed assistance with bathing, shaving, or dentures.During an interview on 03/05/2026 at 4:32 PM, the DON confirmed bathing, shaving, and denture care was not included in R27's care plan and stated these should have been care planned.Review of the facility's policy titled, Comprehensive Person-Centered Care Planning, revised August 2017, indicated It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.Review of the facility's policy titled, Activities of Daily Living (ADLs), revised July 2015, indicated When developing plans of care for ADL'S, ascertain individual resident preferences to ensure the interventions are personalized to include such things as wake time, bed time, meal time, day/time/type of bathing, diversional activities/use of free time, and any other ADL/quality of life choice that is important to the resident.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of the medication manufacturer's instructions, the facility failed to ensure the nurse instructed 2 of 2 residents observed during medication administration (Resident (R) 70 and R123) to rinse their mouths after they were administered an inhaled steroid medication. The deficient practice could result in residents acquiring an oral infection.Findings include:1. Review of R70's Face Sheet located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD).Review of R70's Medication Administration Record (MAR) located under the Orders tab of the electronic medical record (EMR), revealed an order for Breo Ellipta [used to treat COPD] Inhalation Aerosol Powder Breath Activated 100-25 MCG/ACT (Fluticasone Furoate-Vilanterol) one (1) inhalation inhale orally one time a day, originated 03/03/2025.During an observation on 03/04/2026 at 9:04 AM, Licensed Practical Nurse (LPN) 3 administered Breo Ellipta 100-25 milligrams (mg) inhaler to R70 in R70's room. LPN3 did not instruct R70 to rinse his mouth after use. During an interview on 03/04/2026 at 10:55 AM, LPN3 confirmed that R70 did not rinse his mouth after using the Breo Ellipta inhaler and stated, I'm not sure if he needs to rinse his mouth after use. LPN3 reviewed the box for the Breo Ellipta inhaler and confirmed there was a label on the box that stated, Rinse mouth after each use.Review of a prescription drug guide at Drugs.com, revealed the medication, Breo Ellipta, is a steroid inhalation powder and the patient should rinse his/her mouth with water without swallowing to help reduce the risk of oropharyngeal candidiasis. Review of the Highlights of Prescribing Information .Breo Ellipta, dated May 2023, located at https://gskpro.com/content/dam/global/hcpportal/en_US/Prescribing_Information/Breo_Ellipta/pdf/BREO-ELLI read Candida albicans infection of the mouth and pharynx may occur. Advise the patient to rinse his/her mouth with water without swallowing after inhalation to help reduce the risk.2. Review of R123's Face Sheet located in the resident's EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included COPD.Review of R123's MAR located under the Orders tab of the EMR revealed an order for Symbicort [used to treat COPD] Inhalation Aerosol 80-4.5 MCG/ACT (Budesonide- Formoterol Fumarate Dihydrate) (Breyna) two (2) puff inhale orally two times a day, originated 02/24/2026.During an observation on 03/04/2026 at 8:06 AM, LPN2 administered Breyna 80/4.5 micrograms (mcg) inhaler to R123 in R123's room. LPN2 did not instruct R123 to rinse her mouth after use.During an interview on 03/04/2026 at 10:37 AM, LPN2 confirmed R123 did not rinse her mouth after using the Breyna inhaler and stated, I don't think residents have to rinse their mouth after using the inhaler. LPN2 reviewed the Breyna box and confirmed the label stated, Rinse mouth after use.During an interview on 03/05/2026 at 4:32 PM, the Director of Nursing (DON) stated, Residents need to rinse their mouth after using Breyna and Breo Ellipta inhalers. My expectation is that the nurse instructs the residents to rinse their mouth after use.Review of a prescription drug guide at Drugs.com, revealed the medication, Breyna, is an inhaled corticosteroid medication and After inhalation, the patient should rinse the mouth with water without swallowing.Review of the Highlights of Prescribing Information .Breyna, dated February 2025 and located at https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=dc529fc4-bddb-4673-8202-dc401f86166f&ty read Localized infections: Candida albicans infection of the mouth and throat may occur. Monitor patients periodically for signs of adverse effects on the oral cavity. Advise the patient to rinse his/her mouth with water without swallowing after inhalation to help reduce the risk.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to provide staff assistance with activities of daily living (ADLs) for 1 of 2 sampled residents reviewed for ADLs (Resident (R) 27) out of 31 sampled residents. This failure had the potential to lead to a decline in activities of daily living.Findings include:Review of R27's Face Sheet, located under the Profile tab in the electronic medical record (EMR) revealed R27 was admitted on [DATE] and readmitted on [DATE] with diagnoses which included cognitive communication deficit, generalized muscle weakness, dementia, and generalized anxiety disorder.Review of R27's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/13/2026, located under the MDS tab in the EMR, revealed the resident had a Brief Interview of Mental Status (BIMS) score of 14 out of 15 which indicated R27 was cognitively intact. The MDS also indicated R27 required assistance for showering/bathing.During an observation and interview on 03/02/2026 at 9:57 AM, R27 was lying in bed and had an unkept beard. R27stated staff help him shave when they give him a shower. R27 stated he had not had a shower or bathed for 2 weeks. During an observation and interview on 03/04/2026 at 12:55 PM, R27 still had facial hair and stated he still had not had a shower. Review of R27's Showers located under the Tasks tab of the EMR, revealed R27 was scheduled for showers on Mondays and Thursdays during day shift. Documentation showed R27 was last offered and refused a shower on 02/19/26. Review of R27's Documentation Survey Report dated February 2026, located in the resident's EMR under the Reports tab revealed CNA1 documented NA [not applicable] for a shower scheduled on 02/26/2026.During an interview on 03/04/2026 at 12:57 PM, Certified Nursing Assistant (CNA) 6 stated, Residents get showered twice per week and are scheduled twice per week. I work with [R27] once in a while. [R27] should have been showered yesterday. He is scheduled on Tuesday and Fridays during day shift. If a resident refuses, then we have the resident sign a refusal on the shower sheets. During an interview on 03/04/2026 at 1:37 PM, CNA1 stated Residents are showered or bathed twice per week. We document in the computer and on paper. If residents refuse, the resident signs the shower sheet. I've only worked with [R27] twice. I have not showered him. He wasn't scheduled when I worked with him. CNA1 showed the paper CNA assignment sheet that showed R27 was scheduled on Tuesdays and Fridays for a shower and the CNA that is assigned to the shower.During an interview on 03/05/2026 at 4:32 PM, the Director of Nursing (DON) stated the facility did not have documentation showing R27 was offered a shower/bath twice per week. The DON confirmed the resident's shower schedule in the computer was Mondays and Thursdays and the schedule on paper was Mondays and Thursdays. The DON confirmed the last documented shower offered was 02/19/2026. The DON stated it was her expectation that showers/baths were to be offered twice per week. If the resident refused, staff were to offer again later, set up a schedule with the resident, and notify the nurse. The DON also stated CNAs should document the refusal on the paper shower sheet as well as in the computer.Review of the facility's policy titled, Activities of Daily Living (ADLs), revised July 2015, indicated Nursing assistants will provide assistance with ADL's based on the resident's individualized plan of care. ADL support and resident performance will be documented electronically .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, and facility policy review, the facility failed to ensure that staff provided proper catheter care for 1 of 2 residents (Residents (R) 40) reviewed for catheter care out of 31 sampled residents. This failure placed the resident at risk for the transmission of an infection. Findings include: Review of R40's Face Sheet, located under the Profile tab in the electronic medical record (EMR) indicated the resident was admitted to the facility on [DATE] with a diagnosis of neuromuscular dysfunction of the bladder. During observation of catheter care on 03/02/2026 at 9:55 AM, CNA5 wiped R40's perineal area in a downward motion using a disposable wipe. CNA5 obtained another wipe, retracted the foreskin, and wiped twice in a circular motion. CNA5 did not clean R40's urinary catheter, the catheter tubing, or the body of the penis. CNA5 assisted R40 in rolling to his right side. CNA5 then wiped R40's buttocks with a disposable wipe, using a downward motion. It was observed R40 had a bowel movement (BM), and CNA5 was observed wiping BM off her gloves. During an interview on 03/04/2026 at 3:40 PM, CNA5 stated catheter care included using a downward motion to clean, retracting the foreskin, and cleaning the glans of the penis in a circular motion. CNA5 confirmed the body of the penis, the catheter, and catheter tubing should be cleaned when completing catheter care.Interview on 03/04/2026 at 2:53 PM, the Director of Nursing (DON) stated she expected staff to wipe from front to back when cleaning the perineal area and expected to include the shaft of the penis, along with the catheter and catheter tubing. Interview on 03/05/2026 at 3:00 PM, the Infection Preventionist (IP) stated that cleaning a resident should occur from the front to back when cleaning the perineal area. Review of facility policy titled, Indwelling Urinary Catheter Care revised 04/2005, indicated, It is the policy of this facility that each resident with an indwelling catheter care daily and as needed (PRN) to promote hygiene, comfort, and decrease the risk of infection. Procedure.8. [NAME] (put on) gloves.9. Moisten the washcloth and apply soap to the washcloth or using moistened disposable wipes, clean the catheter in a downward motion (front to back) beginning at the urinary meatus (insertion point) and at least four inches down (from resident toward the collection bag). Use a clean portion of the washcloth or fresh disposable wipe for one cleansing motion. 10. Repeat the procedure without soap to rinse as needed. 11. Dry the resident perineal area with a clean cloth. 12. May secure the tubing with a securement device, PRN to prevent migration, friction, or tension of the catheter.15. Remove gloves and perform hand hygiene with soap and water.

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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, record review, and interview, the facility failed to ensure the exterior filter on the oxygen concentrator was clean for 1 of 3 residents reviewed for oxygen use (Resident (R) 9) out of 31 sampled residents. This failure created potential for the oxygen concentrator not to work efficiently, which could have reduced the purity of the oxygen delivered and placed R9 at risk of infection. Findings include:Review of R9's Face Sheet, located under the Profile tab in the Electronic Medical Record (EMR) revealed R9 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included asthma, mucopurulent chronic bronchitis, chronic obstructive pulmonary disease, dependence on supplemental oxygen, and anxiety disorder.Review of R9's annual Minimum Data Set (MDS), with an assessment reference date (ARD) of 01/16/2026 and located under the MDS tab in the EMR revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R9 was cognitively intact. The MDS revealed R9 received oxygen therapy while in the facility.Review of R9's March 2026 Physician Orders located under the Clinical Physician Orders tab in the EMR, revealed the following: a. Change tubing, clean filter and change O2 [oxygen] water bottle every night shift every 7 (seven) days b. Change filter on concentrator every 24 hours as needed c. Clean filter on concentrator Q [every] week, every night shift, every Wed [Wednesday] d. Change oxygen tubing and humidifier bottle every 24 hours as needed e. Oxygen at 2L/M [two liters per minute] via nasal cannula continuously - diagnosis: Chronic respiratory failureReview of R9's February 2026, Treatment Administration Record (TAR) noted: Clean filter on concentrator Q week every night shift every Wed. The filter was noted to have been cleaned on 02/25/2026. There was no indication the filter was cleaned after 02/25/2026 despite it being observed to be very dirty on 03/02/2026. During an observation and interview on 03/02/2026 at 8:54 AM, R9 was in bed with oxygen in place. R9 stated, .I have to have oxygen on always. Observation of the exterior filter on the oxygen concentrator revealed the filter was gray in color with a heavy build-up of dust and dirt. There was no date on the oxygen tubing as to when it had last been changed nor on the oxygen concentrator when the filter had last been cleaned. R9 asked to see the dirty filter and stated, I think they change the tubing every Wednesday, but I don't know when they clean that [filter].On 03/02/2026 at 9:06 AM, the Assistant Director of Nurses (ADON) was asked to observe the filter. The ADON stated, Oh that needs to be changed. When asked who was responsible for checking, changing, and/or cleaning the oxygen concentrator filters, the ADON stated, Let me check, I don't know for sure. I don't want to say the wrong thing. During an interview on 03/05/2026 at 11:22 AM, the Director of Nurses (DON) stated, I was told about the filter. We will need to check that it's being done. The DON did not state who should have cleaned the filter. Review of the oxygen Concentrators [DATE] - [DATE] work history report, provided by the Assistant Director of Nurses (ADON), revealed Cleaning the cabinet filter . remove the filter and clean as needed. Environmental conditions that may require more frequent inspection and cleaning of the filter include, but are not limited to high dust, air pollutants, etc. Clean the cabinet filter with a vacuum cleaner or wash with a mild liquid dish detergent (such as Dawn) and water. Rinse thoroughly. Thoroughly dry the filter and inspect for fraying, crumbling, tears and holes. Replace filter if any damage is found. Reinstall the cabinet filter. The report documented that the task had been completed on 03/01/2026 by maintenance.During an interview on 03/05/2026 at 11:22 AM, the Administrator stated the Maintenance Director had been terminated prior to the survey. There was no additional documentation to indicate that the filter had been cleaned as indicated in the Maintenance report as it was observed to be very dirty on 03/02/2026, one day post cleaning.Review facility's policy titled, Oxygen Administration, dated 03/2026 revealed the following Instructions for external filter cleaning: Filter is to be cleaned every seven (7) days or when visible soiled.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hearthstone	1950 Baring Blvd Sparks, NV 89434

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to implement Enhanced Barrier Precautions (EBP), Transmission Base-Precautions (TBP), and provide care in a manner to prevent cross contamination for 2 of 31 sampled residents (Resident (R) 40 and R15) reviewed for infection control. These failures placed all residents of the facility at risk for the transmission and spread of infections.Findings include: 1. Review of R40's Face Sheet, located under the Profile tab in the electronic medical record (EMR) indicated the resident was admitted to the facility on [DATE] with a diagnosis of neuromuscular dysfunction of the bladder. During an observation on 03/02/2026 at 9:55 AM, a sign posted outside R40's room indicated that R40 was on Enhanced Barrier Precautions. The signage directed staff to perform hand hygiene before and after entering the room. Staff were to don (put on) gloves and gowns prior to entering the room to provide direct care to R40. Continued observation revealed an isolation cart outside of R40's room that contained yellow isolation gowns, and gloves. Certified Nursing Assistant (CNA) 5 was observed in R40's room without a gown on about to start catheter care when the surveyor knocked on R40's door and obtained the resident's permission to observe the catheter care. CNA5 double gloved her hands with two sets of gloves. CNA5 unhung the catheter and laid it on the bed and then emptied the catheter bag. CNA5 removed one set of gloves, placed them in her left gloved hand, and threw them in the waste basket between the bed and nightstand. Continued observation revealed the CNA kept the other pair of gloves on. CNA5 removed the rolled-up cloth drawsheet and brief placing it under R40's left side. CNA5 obtained disposable wipes from the overbed table and completed peri-care, and catheter care, all with the same gloves. Afterwards, CNA5 removed her gloves, and did not wash her hands nor sanitize her hands before placing a new pair of gloves on. CNA5 then assisted R40 in rolling over to his/her right side. CNA5 was cleaning the resident when she was observed wiping her gloves to remove bowel movement (BM) off the gloves. At this time, the CNA5 noticed that she was out of wipes, removed her gloves, and went out of the resident's room to the hallway linen cart and retrieved a package of wipes; however, CNA5 did not perform any type of hand hygiene before exiting the room. CNA5 returned to R40's room without performing hand hygiene or donning the required gown and gloves prior to entering the room. CNA5 finished placing the drawsheet and brief under R40, and adjusted R40's sheet prior to changing her gloves. After removing her gloves, CNA5 did perform any type of hand hygiene prior to leaving the room. Interview on 03/02/2026 at 3:40PM, CNA5 indicated that she was not sure what EBP was nor what type of personal protective equipment (PPE) to use while changing a resident that had a catheter. CNA5 stated she thought that PPE should be worn only when a resident had a wound. CNA5 also indicated she should have changed gloves when she went from dirty area to clean area. Interview on 03/04/2026 at 2:53 PM, the Director of Nursing (DON) stated that any resident that had a catheter was on EBP, which required that staff providing catheter care to wear a gown with gloves at a minimum. The DON indicated that gloves should be changed when going from a dirty area to a clean area, front to back. During an interview on 03/05/2026 at 3:00 PM, the Infection Preventionist (IP) stated the CNA should have worn the proper PPE during R40's catheter care. The IP also stated the CNA should have completed a glove change after she went from a dirty area and before she went back to the clean area. The IP further stated it was her expectation staff would perform hand hygiene in between glove changes. Review of facility's policy titled, Infection Prevention and Control Program, revised 12/2005, indicated, The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program .Scope of the Infection Control and Prevention Program: The infection prevention and control program is comprehensive in that it addresses detection, prevention and control of infections among residents and personnel. (Personnel covers staff, volunteers, visitors, and other individuals providing services under a contractual agreement) .3. The facility personnel will conduct themselves and provide care in a way that (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	minimizes the spread of infection .b. Facility personnel will wash hands after all direct resident contact, for which hand washing is indicated by accepted professional practice. Soap and water must be used at least whenever hands are visibly soiled, after exposure to bodily fluids, after restroom use, and before handling food. Alcohol-based hand sanitizer is appropriate for routine hand hygiene and should be used when moving from a dirty task/area to a clean task/area, provided hands are not visibly contaminated. Review of facility policy titled, Infection Prevention and Control Program Standard and Transmission-Based Precautions revised 03/2026, indicated, Enhanced barrier protections: expand the use of PPE and refer to the use of the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to residents or from resident-to-resident. (e.g., resident with wounds and indwelling medical devices are at especially high risk of both acquisition of a colonization with MDROs). a. PPE: The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with: i. Wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents. ii. MDRO infection or colonization.b. Examples of high-contact resident care activities requiring gown and glove uses for EBP include:.vii. Device care or use:. indwelling urinary catheter.2. Review of R15's Face Sheet located under the Profile tab of the EMR revealed R15 was admitted to the facility on [DATE] with diagnoses which included acute conjunctivitis.Review of R15's Medication Administration Record (MAR) dated March 2026, located under the Orders tab of the EMR, revealed an order for transmission based precautions: contact:Bacterial conjunctivitis: Apply PPE per protocol, originating 03/04/2026.Review of R15's Care Plan located under the Care Plan tab in the EMR revealed R15 was on contact precautions due to bacterial conjunctivitis dated 03/04/2026.Observation on 03/04/2026 at 8:37 AM revealed a Contact Precautions sign was posted outside R15's room. The sign read, Everyone must: clean their hands, including before entering and when leaving the room. Providers and staff must also: put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. Continued observation revealed Licensed Practical Nurse (LPN) 2 performed hand hygiene, donned gloves, and entered R15's room to administer medications. The LPN did not don a gown. The LPN then leaned across R15's bed and administered eye drops to R15. LPN2 forgot something on the medication cart and left the room wearing the same gloves and touched the medication cart with her gloved hands which indicated cross contamination. During an interview on 03/04/2026 at 10:37 AM, LPN2 stated, [R15] was on contact precautions for conjunctivitis. Gloves and gown are worn if changing the resident. I didn't have contact. I just administered eye drops and wore gloves. I didn't sanitize my hands. I don't recall when I removed my gloves. During an interview on 03/04/2026 at 10:44 AM, the Director of Nursing (DON) stated, Gloves and gown are worn when entering a room on contact precautions.Review of the facility's policy titled, IPCP Standard and Transmission Based Precautions, revised March 2026, indicated, Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. [NAME] [put on] PPE [personal protective equipment] upon room entry, then doff [take off] and properly discard PPE and perform hand hygiene before exiting the patient room to contain pathogens.