| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 295050 | A. Building<br>B. Wing | 07/01/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Life Care Center of Reno | 445 W. Holcomb Lane<br>Reno, NV 89511 |

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 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review, the facility failed to ensure consents for psychotropic medications were obtained for 1 of 24 sampled Residents (Resident #421). The deficient practice had the potential to deprive a resident/resident representative of the right to be informed of the medications' purpose, risks, benefits, and potential side effects.<br><br>Findings include:<br><br>Resident #421<br><br>Resident #421 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including bipolar disorder, depression, anxiety disorder unspecified, and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.<br><br>A physician's order dated 06/19/2025, documented Sertraline HCl oral tablet 100 milligram (mg). Give one tablet enterally two times a day for depression, as evidenced by, sad facial expression.<br><br>A physician's order dated 06/19/2025, documented Quetiapine Fumarate oral tablet 50 mg. Give one tablet enterally at bedtime for bipolar disorder, as evidenced by, mood swings.<br><br>A physician's order dated 06/19/2025 documented Buspirone HCl oral tablet 10 mg. Give two tablets enterally two times a day for anxiety, as evidenced by, verbalization of anxiety, 20 mg total.<br><br>Resident #421's care plan initiated on 06/22/2025, documented the resident used antidepressant medication (Sertraline HCl oral tablet) related to depression, as evidenced by, sad facial expression.<br><br>Resident #421's care plan initiated on 06/22/2025, documented the resident used antipsychotic medications (Quetiapine Fumarate oral tablet) related to behavior management/mood swings.<br><br>Resident #421's care plan initiated on 06/24/2025, documented the resident used anti-anxiety medications.<br><br>Resident #421's clinical record lacked psychotropic consent forms indicating the resident accepted to take the medication and was explained risks and benefits associated with the psychotropic medications.<br><br>(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 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/26/2025 at 11:30 AM, the Director of Nursing (DON) explained a psychotropic medication consent gave permission from the resident to administer a psychotropic medication to the resident and provided information to the resident of risks and benefits and side effects associated with the psychotropic medications. The DON confirmed Resident #421 received antipsychotic medications daily and did not have a psychotropic consent completed for the use of Sertraline, Quetiapine, and Buspirone.<br><br>The facility policy titled Psychotropic Medication Informed Consent Policy, last revised 04/22/2025, documented the facility would obtain consent or refused for the use of a psychotropic medication. The consent would document the intended actual benefit of the medication, and justify the potential risks of the medication, and would indicate understanding from the resident and/or resident representative of those risks and benefits.<br><br>The facility policy titled Resident Rights, last revised 09/10/2024, documented the resident had the right to be informed in advance of the risks and benefits of proposed care. |

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|---|---|
| F 0559<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Resident #229<br><br>Resident #229 was admitted to the facility on [DATE], with a diagnosis of encounter for surgical aftercare following surgery on the digestive system.<br><br>Resident #229's clinical record documented the resident was moved to a different room in the facility on 02/19/2025 and on 02/21/2025.<br><br>A Room Change Notification form dated 02/19/2025, documented Resident #229 was moved from room [ROOM NUMBER]-1 to 208-1. The reason for the room change was documented as resident request. The form was signed by the resident.<br><br>A Diet Order and Communication form dated 02/21/2025, included a handwritten checkbox labeled Room Change. The form lacked documentation related to the reason for the room change, the resident being informed prior to the room change, and a signature from the resident.<br><br>The resident's clinical record lacked any additional documentation related to the room change on 02/21/2025.<br><br>On 06/30/2025 at 12:48 PM, the Administrator verbalized the Administrator was unsure of the reason for Resident #229's room change on 02/21/2025 and would have to look into it.<br><br>On 06/30/2025 at 1:29 PM, the Administrator explained Resident #229 was moved to room [ROOM NUMBER] on 02/21/2025 to allow the resident to be in a private/single occupancy room. The Administrator was unable to provide documentation Resident #229 received written notice, including the reason for the change, prior to the 02/21/2025 room change.<br><br>The facility policy titled, Resident Room Relocation, reviewed 09/05/2024, documented Residents had the right to receive written notice, including the reason for the change, before the resident's room in the facility was changed.<br><br>Cross reference with F745.<br><br>Based on clinical record review, interview, and document review, the facility failed to provide written notice, including the reason for a room change, to 37 of 49 residents (Residents #71, #56, #72, #83, #75, #372, #271, #85, #222, #88, #370, #78, #20, #65, #6, #32, #38, #33, #375, #223, #41, #376, #79, #35, #27, #44, #96, #275, #34, #227, #175, #177, #2, #377, #25, #91, and #171) who were relocated within the facility and 1 of 4 discharged residents reviewed (Resident #229). The widespread deficient practice had the potential to result in, more than minimal psychosocial harm to affected residents, and reflects a systemic issue.<br><br>Findings include:<br><br>The Resident Listing Report dated 06/22/2025, identified the following current residents with a room change from August 2024 through June 2025:<br><br>(continued on next page) |

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|---|---|
| F 0559<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -Resident #71 changed rooms on 09/12/2025.<br>-Resident #56 changed rooms on 02/14/2025.<br>-Resident #72 changed rooms on 05/28/2025.<br>-Resident #83 changed rooms on 05/02/2025.<br>-Resident #75 changed rooms on 04/04/2025.<br>-Resident #372 changed rooms on 04/10/2025.<br>-Resident #271 changed rooms on 01/05/2025.<br>-Resident #85 changed rooms on 05/12/2025.<br>-Resident #222 changed rooms on 05/06/2025.<br>-Resident #88 changed rooms on 06/25/2025.<br>-Resident #370 changed rooms on 02/21/2025.<br>-Resident #78 changed rooms on 12/06/2024.<br>-Resident #20 changed rooms on 06/09/2025.<br>-Resident #65 changed rooms on 05/29/2025.<br>-Resident #6 changed rooms on 02/23/2025.<br>-Resident #32 changed rooms on 04/24/2025.<br>-Resident #38 changed rooms on 06/06/2025.<br>-Resident #33 changed rooms on 06/13/2025.<br>-Resident #375 changed rooms on 06/10/2025.<br>-Resident #223 changed rooms on 04/10/2025.<br>-Resident #41 changed rooms on 04/28/2025.<br>-Resident #376 changed rooms on 06/16/2025.<br>-Resident #79 changed rooms on 06/09/2025.<br>-Resident #35 changed rooms on 11/25/2024.<br>(continued on next page) |

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| F 0559<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -Resident #27 changed rooms on 01/08/2025.<br><br>-Resident #44 changed rooms on 06/17/2025.<br><br>-Resident #96 changed rooms on 05/30/2025.<br><br>-Resident #275 changed rooms on 06/17/2025.<br><br>-Resident #34 changed rooms on 02/19/2025.<br><br>-Resident #227 changed rooms on 06/23/2025.<br><br>-Resident #175 changed rooms on 10/16/2024.<br><br>-Resident #177 changed rooms on 06/05/2025.<br><br>-Resident #2 changed rooms on 05/27/2025.<br><br>-Resident #377 changed rooms on 06/16/2025.<br><br>-Resident #25 changed rooms on 05/07/2025.<br><br>-Resident #91 changed rooms on 06/19/2025.<br><br>-Resident #171 changed rooms on 06/19/2025.<br><br>Resident #71<br><br>Resident #71 was admitted to the facility on [DATE], with a primary diagnosis of encounter for surgical aftercare following surgery on the skin and subcutaneous tissue.<br><br>Resident #56<br><br>Resident #56 was admitted to the facility on [DATE], and readmitted on [DATE], with a primary diagnosis of unspecified fracture of lower end of left femur, subsequent encounter for closed fracture with routine healing.<br><br>Resident #72<br><br>Resident #72 was admitted to the facility on [DATE], and readmitted on [DATE], with a primary diagnosis of encounter for surgical aftercare following surgery on the skin and subcutaneous tissue.<br><br>Resident #83<br><br>Resident #83 was admitted to the facility on [DATE], with a primary diagnosis of hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left non-dominant side.<br><br>Resident #75<br><br>(continued on next page) |

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|---|---|
| F 0559<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Resident #75 was admitted to the facility on [DATE], with a primary diagnosis of displaced intertrochanteric fracture of left femur subsequent encounter for closed fracture with routine healing.<br><br>Resident #372<br><br>Resident #372's was admitted to the facility on [DATE], and readmitted on [DATE], with a primary diagnosis of acute pyelonephritis.<br><br>Resident #271<br><br>Resident #271 was admitted to the facility on [DATE], with a primary diagnosis of alcoholic polyneuropathy.<br><br>Resident #85<br><br>Resident #85 was admitted to the facility on [DATE], and readmitted on [DATE], with a primary diagnosis of encounter for orthopedic aftercare following surgical amputation.<br><br>Resident #222<br><br>Resident #222 was admitted to the facility on [DATE], with a primary diagnosis of displaced fracture of greater trochanter of left femur initial encounter for open fracture<br><br>Resident #88<br><br>Resident #88 was admitted to the facility on [DATE], with a primary diagnosis of acute eosinophilic pneumonia.<br><br>Resident #370<br><br>Resident #370 was admitted to the facility on [DATE], with a primary diagnosis of enterocolitis due to clostridium difficile not specified as recurrent.<br><br>Resident #78<br><br>Resident #78 was admitted to the facility on [DATE], with a primary diagnosis of acute respiratory failure with hypoxia.<br><br>Resident #20<br><br>Resident #20 was admitted to the facility on [DATE], with a primary diagnosis of acute and chronic respiratory failure with hypoxia.<br><br>Resident #65<br><br>Resident #65 was admitted to the facility on [DATE], with a primary diagnosis of encounter for orthopedic aftercare following surgical amputation.<br><br>(continued on next page) |

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|---|---|
| F 0559<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Resident #6<br><br>Resident #6 was admitted to the facility on [DATE], and readmitted on [DATE], with a primary diagnosis of other fracture of right femur, initial encounter for closed fracture.<br><br>Resident #32<br><br>Resident #32 was admitted to the facility on [DATE], with a primary diagnosis of aftercare following joint replacement surgery.<br><br>Resident #38<br><br>Resident #38 was admitted to the facility on [DATE], and readmitted on [DATE], with a primary diagnosis of acute pyelonephritis.<br><br>Resident #33<br><br>Resident #33 was admitted to the facility on [DATE], with a primary diagnosis of fracture of unspecified part of the neck of right femur, subsequent encounter for closed fracture with routine healing.<br><br>Resident #375<br><br>Resident #375 was admitted to the facility on [DATE], with a primary diagnosis of encounter for surgical aftercare following surgery on the circulatory system.<br><br>Resident #223<br><br>Resident #223 was admitted to the facility on [DATE], with a primary diagnosis of encounter for surgical aftercare following surgery on the circulatory system.<br><br>Resident #41<br><br>Resident #41 was admitted to the facility on [DATE], with a primary diagnosis of acute and chronic respiratory failure with hypoxia.<br><br>Resident #376<br><br>Resident #376 was admitted to the facility on [DATE], with a primary diagnosis of pneumonia, unspecified organism.<br><br>Resident #79<br><br>Resident #79 was admitted to the facility on [DATE], with hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side.<br><br>Resident #35<br><br>(continued on next page) |

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| F 0559<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Resident #35 was admitted to the facility on [DATE], and readmitted on [DATE], with a primary diagnosis of other sequelae of cerebral infarction.<br><br>Resident #27<br><br>Resident #27 was admitted to the facility on [DATE], and readmitted on [DATE], with a primary diagnosis of metabolic encephalopathy.<br><br>Resident #44<br><br>Resident #44 was admitted to the facility on [DATE], with a primary diagnosis of spinal stenosis, lumbar region with neurogenic claudication.<br><br>Resident #96<br><br>Resident #96 was admitted to the facility on [DATE], and readmitted on [DATE], with a primary diagnosis of unspecified atrial fibrillation.<br><br>Resident #275<br><br>Resident #275 was admitted to the facility on [DATE], with a primary diagnosis of encounter for surgical aftercare following surgery on the nervous system.<br><br>Resident #34<br><br>Resident #34 was admitted to the facility on [DATE], with a primary diagnosis of cerebral infarction due to embolism of left middle cerebral artery.<br><br>Resident #227<br><br>Resident #227 was admitted to the facility on [DATE], and readmitted on /28/2025, with a primary diagnosis of unspecified intracapsular fracture of right femur, subsequent encounter for closed fracture with routine healing.<br><br>Resident #175<br><br>Resident #175 was admitted to the facility on [DATE], with a primary diagnosis of zoster without complications.<br><br>Resident #177<br><br>Resident #177 was admitted to the facility on [DATE], and readmitted on [DATE], with a primary diagnosis of urinary tract infection, site not specified.<br><br>Resident #2<br><br>(continued on next page) |

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| F 0559<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Resident #2 was admitted to the facility on [DATE], and readmitted on [DATE], with a primary diagnosis of unspecified fracture of right acetabulum, subsequent encounter for fracture with routing healing.<br><br>Resident #377<br><br>Resident #377 was admitted to the facility on [DATE], with a primary diagnosis of fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing.<br><br>Resident #25<br><br>Resident #25 was admitted to the facility on [DATE], with a primary diagnosis of chronic respiratory failure with hypoxia.<br><br>Resident #91<br><br>Resident #91 was admitted to the facility on [DATE], with a primary diagnosis of neutropenia, unspecified.<br><br>Resident #171<br><br>Resident #171 was admitted to the facility on [DATE], with a primary diagnosis of unspecified nondisplaced fracture of surgical neck of right humerus, subsequent encounter for fracture with routine healing.<br><br>On 06/23/2025 at 9:33 AM, Resident #171 verbalized approximately five days prior, the resident was evicted from their previous room in the 400 unit of an adjacent building within the same facility. The resident was told by facility staff not to speak to Resident #171's roommate and when they continued to speak, Resident #171 was moved to their new room. Resident #171 verbalized the resident did not want to move rooms as the resident liked their previous roommate.<br><br>Room Change Notification Forms were provided for the following residents identified in the Resident Listing Report, however lacked documentation of the reason for the room changes: Residents #71, #88, #375, #223, #376, #79, #34, #227, #177, #377, and #91.<br><br>The following clinical records lacked documented evidence of a room change notification completed prior to the room changes identified in the Resident Listing Report: Residents #56, #72, #83, #75, #372, #271, #85, #222, #370, #78, #20, #65, #6, #32, #38, #33, #41, #35, #27, #44, #96, #275, #175, #2, #25, and #171.<br><br>On 06/25/2025 at 1:58 PM, the Licensed Social Worker (LSW) verbalized room change notifications were important because residents had the right to decide to change rooms.<br><br>On 06/25/2025 at 1:58 PM, the Director of Nursing (DON) verbalized room change notifications were expected to be completed prior to every room change. The DON confirmed Resident #171's clinical record lacked documented evidence of a room change notification for the 06/19/2025 room change. The DON explained the lack of room change notifications was a pervasive issue in the facility.<br><br>(continued on next page) |

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| F 0559<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 06/30/2025 at 1:00 PM, the Medical Director (MD) explained prior to the room change, Resident #171 and their previous roommate discussed their medications and other healthcare needs. Resident #171 attempted to direct the roommate's care, leading to frustration from facility staff and Resident #171. The MD verbalized to mitigate the privacy risk and address the personality conflicts between Resident #171 and the staff responsible for the room in the 400 unit, the facility requested Resident #171 move to a private room.<br><br>On 06/26/2025 at 9:54 AM, the Administrator verbalized all residents with a room change should have a room change notification with a reason for room change documented.<br><br>On 06/26/2025 at 9:54 AM, the Administrator verbalized all residents with a room change should have a room change notification with a reason for room change documented.<br><br>The Administrator confirmed the aforementioned residents lacked room change notifications with the reason for room change prior to changing rooms. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interview, and document review, the facility failed to ensure a Minimum Data Set 3.0 (MDS) assessment was accurate for 3 of 24 sampled residents (Resident #421, #2 and #171). This deficient practice had the potential to deprive residents of necessary care and services relative to current health management needs in the facility.<br><br>Findings include:<br><br>Resident #421<br><br>Resident #421 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including bipolar disorder, depression, anxiety disorder unspecified, and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.<br><br>A physician's order dated 06/19/2025, documented Quetiapine Fumarate oral tablet 50 mg. Give one tablet enterally at bedtime for bipolar disorder, as evidenced by, mood swings.<br><br>A physician's order dated 06/19/2025, documented Sertraline HCl oral tablet 100 milligram (mg). Give one tablet enterally two times a day for depression, as evidenced by, sad facial expression.<br><br>Resident #421's Medication Administration Record (MAR) for June 2025 documented Quetiapine Fumarate 50 mg tablet was administered to the resident from 06/19/2025 to current.<br><br>Resident #421's MAR for June 2025 documented Sertraline HCl 100 mg tablet was administered to the resident from 06/19/2025 to current.<br><br>An MDS assessment dated [DATE], Section I - Active Diagnoses, Psychiatric/Mood Disorder lacked an X or any other documentation the resident had diagnoses of bipolar disorder and depression.<br><br>On 06/26/2025 at 11:30 AM, the Director of Nursing (DON) explained the resident had diagnoses to include bipolar disorder and depression and was being administered antipsychotic medications used to treat the diagnoses. The DON verbalized those diagnoses should be documented on the MDS to accurately identify care concerns for the resident. The DON confirmed the diagnoses of bipolar and depression were not documented on the resident's MDS.<br><br>On 06/26/2025 at 9:45 AM, the MDS Coordinator explained the resident diagnoses were input on the resident MDS assessments and needed to be accurate. Bipolar disorder and depression needed to be input on the residents' MDS if a resident had those diagnoses. The MDS Coordinator confirmed Resident #421 had diagnoses of bipolar disorder and depression and the assessment was inaccurate.<br><br>Resident #2<br><br>Resident #2 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including end stage renal disease, dependence on renal dialysis, muscle weakness, and difficulty walking.<br><br>(continued on next page) |

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| | 295050 | A. Building<br>B. Wing | 07/01/2025 |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An Event Note dated 05/07/2025, documented the resident had fallen while attempting to self-transfer.<br><br>A Transfer to Hospital Summary dated 05/07/2025, documented Resident #2 was to be transferred and admitted to the hospital due to a fracture of the right hip.<br><br>Resident #2's Minimum Data Set (MDS) 3.0 dated 05/07/2025, Discharge Return Anticipated, Section J-Health Conditions, J1800 documented: Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), Has the resident had any falls since admission/entry or reentry or the prior assessment (OBRA or Scheduled PPS), whichever is more recent? No.<br><br>On 06/26/2025 at 11:05 AM, the MDS Coordinator, Registered Nurse (RN) confirmed Resident #2's MDS dated [DATE] was not coded correctly and did not reflect the resident's fall with injury. The MDS Coordinator RN confirmed Section J1800 should have been coded as yes since the fall with injury was the reason for the transfer to the hospital.<br><br>On 06/26/2025 at 11:08 AM, the MDS Coordinator RN verbalized having followed the MDS 3.0 Resident Assessment Instrument (RAI) Manual to complete resident assessments.<br><br>Resident #171<br><br>Resident #171 was admitted to the facility on [DATE], with a primary diagnosis of unspecified nondisplaced fracture of surgical neck of right humerus, subsequent encounter for fracture with routine healing.<br><br>A physician's order dated 06/13/2025, documented Hydroxyzine Hydrochloride (HCl) 10 mg tablet. Give one tablet by mouth two times a day for anxiety as exhibited by verbalization of anxiety for 14 days.<br><br>Resident #171's June 2025 MAR documented Hydroxyzine HCl was administered the night of 06/13/2025, twice daily from 06/14/2025 through 06/26/2025, and the morning of 06/27/2025.<br><br>Resident #171's Admissions MDS assessment dated [DATE], section N0415 (Medications - High-Risk Drug Classes: Use and Indication) lacked an X or any other documentation an antianxiety medication was administered to the resident during the seven-day lookback period.<br><br>On 06/30/2025 at 11:09 AM, a RN confirmed Resident #171's clinical record documented an order of Hydroxyzine HCl with an indication of anxiety.<br><br>On 06/30/2025 at 12:02 PM, the MDS Coordinator verbalized using the RAI Manual to guide MDS activities. It was important MDS Assessments be accurate to accurately convey resident needs.<br><br>The MDS Coordinator confirmed Resident #171 received Hydroxyzine HCl from 06/13/2025 through 06/27/2025. Hydroxyzine HCl was classified as an antianxiety medication and should have been reflected on the MDS Assessment. |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure an initial Preadmission Screening and Resident Review (PASARR) was completed prior to a resident's admission for 1 of 24 sampled residents (Resident #421). The deficient practice had a potential for a newly admitted resident not to receive the necessary screening for the appropriateness to be admitted to a skilled nursing facility.<br><br>Findings include:<br><br>Resident #421<br><br>Resident #421 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including bipolar disorder, depression, anxiety disorder unspecified, and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.<br><br>On 06/25/2025, during review of Resident #421's clinical record, a PASSAR Level 1 could not be located.<br><br>Resident #421's Care Plan, initiated on 06/22/2025, documented the resident was on psychotropic medications related to behavior management, mood swings, depression, and anxiety.<br><br>On 06/25/2025 at 3:41 PM, the Regional Director of Clinical Services provided a PASSAR Level 1 submission submitted on 04/09/2008, however verbalized a PASSAR Level 1 could not be located for the resident. The Regional Director of Clinical Services verbalized being unaware if the resident was receiving psychiatric services.<br><br>On 06/25/2025 at 4:39 PM, the Regional Director of Clinical Services confirmed the facility did not have a PASSAR Level 1 completed for Resident #421 to determine if the resident was appropriate for Skilled Nursing Facility placement. The Regional Director of Clinical Services explained residents could not admit to a facility without a PASSAR Level 1.<br><br>On 06/25/2025 at 4:40 PM, the Director of Nursing (DON) explained Resident #421 did not require a PASSAR Level 1 in order to be admitted to a Skilled Nursing Facility based off of the resident's diagnoses and could not explain why the purpose of a PASSAR Level 1 would be important for a resident.<br><br>On 06/26/2025 at 9:04 AM, the Business Office Manager (BOM) explained when residents were admitted to the facility, a PASSAR Level 1 was required to be obtained to determine proper placement and services a resident may need. The BOM confirmed the facility did not have a PASSAR Level 1 for Resident #421 and a PASSAR Level 1 submission from 2008 would be inappropriate to use because the admitting diagnoses of a resident could be different from diagnoses in 2008.<br><br>On 06/26/2025 at 9:39 AM, the Director of Clinical Services explained the facility reviewed the last two years of diagnoses for a resident. If the resident did not have mental illness diagnoses prior to the last two years but had mental illness diagnoses now, the facility needed to submit for a PASARR Level 1 to cover all care areas for the resident.<br><br>(continued on next page) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility policy titled Pre-admission Screening and Resident Review (PASARR), last reviewed 09/26/2024, documented a PASSAR Level 1 screening was to be completed for residents prior to admission to the facility and a record would be retained in the resident's medical record. |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, document review, and interview, the facility failed to ensure a baseline care plan was developed to address the care and interventions for mental health diagnoses for 1 of 24 sampled residents (Resident #421) and to ensure the proper care and services for a resident with a Foley catheter for 1 of 24 sampled residents (Resident #69). The deficient practice had the potential to deprive a resident of proper care and services related to mental health conditions and the potential to place the resident at risk for not receiving appropriate care related to a Foley catheter.<br><br>Findings include:<br><br>Resident #421<br><br>Resident #421 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including bipolar disorder, depression, anxiety disorder unspecified, and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.<br><br>Resident #421's physician's orders documented:<br><br>-Quetiapine Fumarate oral tablet 50 milligram (mg). Give one tablet enterally at bedtime for bipolar disorder, as evidenced by mood swings. The physician's order was dated 06/19/2025.<br><br>-Buspirone HCl oral tablet 10 mg. Give two tablets enterally two times a day for anxiety, as evidenced by verbalization of anxiety, 20 mg total. The physician's order was dated 06/19/2025.<br><br>Resident #421's baseline care plan dated 06/19/2025, lacked a care plan for the care, treatment, and interventions for bipolar disorder and anxiety.<br><br>On 06/26/2025 at 11:30 AM, the Director of Nursing (DON) reviewed Resident #421's baseline care plan and confirmed the diagnoses of bipolar disorder and anxiety were not included on the resident's care plan. The DON explained a care plan for the diagnoses would be beneficial for the facility to understand the care needs of the resident and how to properly care for the resident.<br><br>Resident #69<br><br>Resident #69 was admitted to the facility on [DATE], with diagnoses including retention of urine, unspecified, benign prostatic hyperplasia without lower urinary tract symptoms, and chronic combined systolic (congestive) and diastolic (congestive) heart failure.<br><br>A physician's order dated 06/09/2025, documented indwelling catheter to straight drainage. Size : 16 French Bulb; 10 milliliter (ml). Change for clogging or dislodgement as needed for benign prostatic hyperplasia for infection, obstruction or when the closed system is compromised.<br><br>The admission Minimum Data Set (MDS) 3.0 dated 06/12/2025, Section H-Bladder and Bowel, documented the resident had an indwelling catheter.<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A baseline care plan dated 06/10/2025, documented the resident had (SPECIFY: Condom/Intermittent/Indwelling Suprapubic) Catheter. The interventions included:<br><br>-catheter care every shift;<br><br>-educate resident and/or family regarding indwelling catheter and care;<br><br>-enhanced barrier precautions.<br><br>On 06/25/2025, the Director of Nursing (DON) explained Resident #69 had a Foley catheter and confirmed the resident's care plan did not specify what type of catheter the resident had nor proper interventions for care related to the catheter. The interventions the DON expected to see on a Foley catheter care plan would be type of care for the catheter, goals and expectations for the catheter, the type and size of the catheter, observing for pain/discomfort, and checking the Foley catheter for placement. The DON verbalized the information would be important to include on the resident's care plan for staff to refer for care needs for the resident.<br><br>On 06/25/2025 at 1:09 PM, the Regional Director of Clinical Services confirmed the care plan was not completed for Resident #69 and explained the Foley catheter was critical to care plan for the care of this resident. The Regional Director of Clinical Services verbalized a care plan should never document the word specify in place of the specific care area.<br><br>The facility policy titled Baseline Care Plan, last reviewed 09/05/2024, documented a baseline care plan would be developed within 48 hours of a resident admission to the facility and the care plan would be updated to reflect current care needs of the resident.<br><br>The facility policy titled Indwelling urinary catheter (Foley) care and management', undated, documented monitoring of the catheter daily and assess for complications resulting from the use of an indwelling catheter, such as, symptoms of blockage associated with bypassing of urine, catheter associated urinary tract infection (CAUTI), expulsion of the catheter, pain, discomfort, and bleeding. An individual care plan based on the information would be developed and revised as necessary. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review, the facility failed to develop a person-centered Comprehensive Care Plan for the needed care and services related to 1) a Foley catheter for 1 of 24 sampled residents (Resident #69), 2) bowel and bladder retraining for 2 of 24 sampled resident (Resident #9 and #54), and 3) pain management for 1 of 24 sampled residents (Resident #223). This deficient practice had the potential to delay adequate care and interventions to properly manage concerns related to Foley catheter care, bowel and bladder retraining, and pain management.<br><br>Findings include:<br><br>Resident #69<br><br>Resident #69 was admitted to the facility on [DATE], with diagnoses including retention of urine, unspecified, benign prostatic hyperplasia without lower urinary tract symptoms, and chronic combined systolic (congestive) and diastolic (congestive) heart failure.<br><br>A physician's order dated 06/09/2025, documented indwelling catheter to straight drainage. Size : 16 French Bulb; 10 milliliter (ml). Change for clogging or dislodgement as needed for benign prostatic hyperplasia for infection, obstruction or when the closed system is compromised.<br><br>The admission Minimum Data Set (MDS) 3.0 dated 06/12/2025, Section H-Bladder and Bowel, documented the resident had an indwelling catheter.<br><br>A care plan dated 06/10/2025, documented the resident had (SPECIFY: Condom/Intermittent/Indwelling Suprapubic) Catheter:. The interventions included:<br><br>-catheter care every shift;<br><br>-educate resident and/or family regarding indwelling catheter and care;<br><br>-enhanced barrier precautions.<br><br>On 06/25/2025 at 8:48 AM, the Director of Nursing (DON) explained Resident #69 had a Foley catheter and confirmed the resident's care plan was not revised and did not specify what type of catheter the resident had nor proper interventions for care related to the catheter. The interventions the DON expected to see on a Foley catheter care plan would be type of care for the catheter, foals and expectations for the catheter, the type and size of the catheter, observing for pain/discomfort, and checking the Foley catheter for placement. The DON verbalized the information would be important to include on the resident's care plan for staff to refer for care needs for the resident.<br><br>On 06/25/2025 at 1:09 PM, the Regional Director of Clinical Services confirmed the care plan was not completed and not revised for Resident #69 and explained the Foley catheter was critical to care plan for the care of this resident. The Regional Director of Clinical Services verbalized a care plan should never document the word specify in place of the specific care area.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility policy titled Indwelling urinary catheter (Foley) care and management, undated, documented monitoring of the catheter daily and assess for complications resulting from the use of an indwelling catheter, such as, symptoms of blockage associated with bypassing of urine, catheter associated urinary tract infection (CAUTI), expulsion of the catheter, pain, discomfort, and bleeding. An individual care plan based on the information would be developed and revised as necessary.<br><br>Resident #9<br><br>Resident #9 was admitted to the facility on [DATE], with a principal diagnosis of pneumonia due to other gram-negative bacteria.<br><br>Resident #9's Minimum Data Set 3.0 (MDS) assessment dated [DATE], section H (Bladder and Bowel) documented the following:<br><br>-A trial of a toileting program had not been attempted.<br><br>-The resident was always incontinent of bladder.<br><br>-The resident was always incontinent of bowel.<br><br>-A toileting program was not being used to manage the resident's bowel incontinence.<br><br>A care plan dated 05/21/2025, documented the resident had urinary incontinence. The care plan did not include individualized, measurable objectives or specific interventions for bowel and bladder management, nor did it reflect the resident's goals or preferences.<br><br>The interventions included:<br><br>-assist with toileting as needed<br><br>-offer toilet before meals and at bed time;<br><br>-peri care as needed.<br><br>On 06/26/2025 at 2:13 PM, the DON explained the bowel and bladder evaluation was completed upon admission to determine the resident's continence status. Once the resident's continence status was determined the evaluation was completed and the score would determine the interventions appropriate for the resident. The DON confirmed Resident #9 was a candidate for toileting, timed or scheduled voiding, and lacked person centered interventions and was unable to determine if the intervention of rounding every two hours was appropriate or an effective intervention for Resident #9.<br><br>The facility policy titled Comprehensive Care Plans and Revisions, last reviewed 09/11/2024, documented the facility should monitor the resident to help identify changes in a resident's condition that may warrant an update to the person-centered plan of care. The plan of care would document interventions on existing problems, updating goals or problem statements, and adding short term problems, goals, and interventions to address a condition. Resident #54<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #54 was admitted to the facility on [DATE], with diagnoses including encounter for surgical aftercare following surgery on the digestive system and acute (reversible) ischemia of small intestine, extent unspecified.<br><br>Resident #54's MDS assessment dated [DATE], section H (Bladder and Bowel) documented the following:<br><br>-A trial of a urinary toileting program had not been attempted.<br><br>-The resident was frequently incontinent of urine.<br><br>-The resident was frequently incontinent of bowel.<br><br>-A toileting program was not being used to manage the resident's bowel incontinence.<br><br>An Evaluation for Bowel and Bladder Training dated 06/07/2025, documented Resident #54 was a candidate for toileting, timed or scheduled voiding.<br><br>Resident #54's Care Plan included the following:<br><br>-Focus: Bowel Incontinence. Goal: Resident would have no skin breakdown related to bowel incontinence. Interventions included assist with toileting as needed and pericare as needed. The date initiated was 06/08/2025.<br><br>-Focus: Urinary Incontinence. Goal: Resident would have no skin breakdown related to urinary incontinence. Interventions included assist with toileting as needed and pericare as needed. The date initiated was 06/08/2025.<br><br>On 06/26/2025 at 2:13 PM, the DON explained a resident's continence status was assessed upon admission using a bowel and bladder assessment in the facility's electronic medical record (EMR) system. After the assessment was complete, interventions to help manage incontinence would be added to the resident's care plan.<br><br>The DON confirmed Resident #54's Evaluation for Bowel and Bladder Training documented the resident was a candidate for toileting, timed or scheduled voiding and the resident's Care Plan lacked resident-specific interventions to maintain continence and/or restore as much normal bowel and bladder function as possible.<br><br>Resident #223<br><br>Resident #223 was admitted to the facility on [DATE], with diagnoses including encounter for surgical aftercare following surgery on the circulatory system and chronic pain syndrome.<br><br>On 06/24/2025 at 9:05 AM, Resident #223 verbalized the resident had chronic pain and regularly took pain medication at home to manage the pain. The resident reported having current abdominal and back pain, the pain was rated ten on a 0-10 scale, and the pain prevented the resident from walking.<br><br>Resident #223's MDS assessment dated [DATE], Section J (Health Conditions) documented the following within the previous five days:<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The resident had received As Needed (PRN) pain medications or PRN pain medications had been offered and declined.<br><br>-The resident had not received a non-medication intervention for pain.<br><br>-The resident had pain or hurting.<br><br>-The pain rarely made hard for the resident to sleep.<br><br>-The pain occasionally limited participation in rehabilitation therapy sessions and limited day-to-day activities.<br><br>Resident #223's Care Plan documented the following focuses, goals and interventions:<br><br>-Focus: Resident at risk for rehospitalization due to congestive heart failure, atrial fibrillation, pulmonary embolism, obesity, and chronic pain. Interventions included: Provide medications as ordered, interdisciplinary team to meet as needed to discuss resident's condition and interventions. The date initiated was 06/20/2025.<br><br>-Focus: Resident is on pain medication therapy related to congestive heart failure, pulmonary embolism, and bilateral lower extremity edema. Goal: The resident would be free of any discomfort or adverse side effects from pain medication. Interventions included: Administer analgesic medications as ordered by physician. Observe for side effects and effectiveness every shift. The date initiated was 06/22/2025.<br><br>-Focus: Resident expresses pain/discomfort related to chronic pain disorder. Goal: The resident will express pain relief. Interventions included: Educate resident regarding pain management, evaluate effectiveness of pain interventions, pain medications as ordered. The date initiated was 06/20/2025 and the revised date was 06/22/2025.<br><br>Resident #223's Order Summary Report included the following physician orders:<br><br>-PainAD Assessment: Location of pain: 1) generalized, 2) back, 3) leg, 4) head. Attempt non-med interventions prior to administering PRN pain medications: 1) calm/quiet environment, 2) reposition, 3) redirection, 4) elevate extremities. Every shift, do not arouse from sleep. Do not exceed 3,000 milligrams (mg) Acetaminophen in a 24 hours period from all sources. Document pain level, location of pain, and intervention used.<br><br>-Acetaminophen tablet 325 mg, give two tablets by mouth every four hours as needed for pain scale 1-3.<br><br>-Oxycodone Hydrochloride (HCl) oral tablet 5 mg, give one tablet by mouth every four hours as needed for pain scale 4-6.<br><br>-Oxycodone HCl oral tablet 5 mg, give two tablets by mouth every four hours as needed for pain scale 7-10.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/30/2025 at 9:59 AM, the DON verbalized the facility ensured both non-pharmacological and pharmacological interventions were used to manage residents' pain by asking the resident about which non-pharmacological interventions the resident had used in the past. Staff were to attempt non-pharmacological interventions for pain prior to administering medication. The DON confirmed all interventions being used to manage a resident's pain should be included on the resident's Care Plan.<br><br>The DON confirmed Resident #223 had pain and verbalized interventions for pain management for the resident included Oxycodone, Tylenol, elevation of extremities, calm and quite environment, repositioning and redirection. The DON confirmed the non-pharmacological interventions were not on the resident's care plan.<br><br>The facility policy titled Area of Focus: Care Planning - Baseline, Comprehensive, and Routine Updates, reviewed 11/25/2024, documented a comprehensive care plan was to be completed to address the resident's goals and preferences, contain measurable objectives and timeframes, and interventions to assist the resident to meet their goals. Selecting interventions and planning care included identifying and implementing interventions and treatments to address the individual's physical, functional, and psychosocial needs, concerns, problems and risks.<br><br>Cross reference tag F690 and F697 |

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| F 0678<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on personnel record review, document review and interview, the facility failed to ensure an employee had current cardiopulmonary resuscitation (CPR) training. This deficient practice placed residents at risk from an employee not having completed all employment eligibility requirements.<br><br>Findings include:<br><br>Employee #9<br><br>Employee #9 had a hire date of [DATE] and a title of Certified Nursing Assistant.<br><br>Employee #9's personnel record documented a CPR certification with an expiration date of [DATE].<br><br>On [DATE] at 8:39 AM, the Staff Development Coordinator, Registered Nurse (RN), verbalized having been responsible to ensure all staff received the required certifications and confirmed Employee #9's CPR certification had expired on [DATE]. The Staff Development Coordinator RN verbalized not having been sure if Employee #9 had current CPR training.<br><br>Employee #9's job description, signed by Employee #9 on [DATE], documented the employee must have obtained CPR certification and the certification must remain current during employment.<br><br>The facility policy titled, Cardiopulmonary Resuscitation (CPR) Policy, revised [DATE], documented employees must maintain current CPR certification for those employees providing care to residents. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, interview, and document review, the facility failed to ensure communication was maintained between the facility and the hospice agency providing care to 1 of 1 hospice residents residing in the facility (Resident #27) This deficient practice had the potential to result in the facility not being updated regarding the care the resident was receiving from the hospice agency, changes in the resident's condition, changes to frequency of care, new physician orders, and instructions for new physician orders.<br><br>Findings include:<br><br>Resident #27<br><br>Resident #27 was admitted to the facility on [DATE], with diagnoses including metabolic encephalopathy, paraplegia incomplete, and malignant neoplasm of the brain.<br><br>A physician's order dated 02/22/2025, documented to admit Resident #27 to Hospice for a diagnosis of glioblastoma of the brain (a malignant neoplasm).<br><br>Resident #27's Hospice Care Binder was located at the nurses' station. The Binder included a nurse visit progress note dated 02/21/2025, and did not include any additional progress notes from the hospice.<br><br>On 06/30/25 at 10:26 AM, a Registered Nurse (RN) verbalized a resident's hospice binder was important because the binder was reviewed by facility nurses. The Hospice Nurse Notes were reviewed to determine if there was anything new regarding the resident or the resident's care the facility nurse should have been aware of. The RN confirmed the Hospice Nurse Notes should be located in the resident's Hospice Binder under nurse progress notes, and confirmed the notes were not present as expected in Resident #27's Hospice Binder.<br><br>On 06/30/25 at 11:23 AM , the Director of Nursing (DON) verbalized the DON's expectation was a Nurse's note for each hospice visit would be in the resident's hospice binder. The DON verbalized all the notes from the hospice nurse visits were to be placed into the same section of the Hospice Binder. The DON explained nursing staff used the hospice nurse notes as a reference for care of the resident and included the resident's status.<br><br>On 06/30/25 at 11:26 AM, the DON explained the facilities Interdisciplinary Team (IDT) reviewed hospice patient care every Wednesday Morning, including the nurse progress notes located in the Hospice Binder. The progress notes were used to help the IDT understand/know the care the resident was receiving and guide discussion related to the resident's care. The DON confirmed Hospice Binders were reviewed weekly in IDT meetings and confirmed the absence of the Hospice Nurse progress notes should have been identified and this time.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/30/25 at 11:33 AM, the DON reviewed Resident #27's Hospice Binder and confirmed the Hospice Nurse Progress Note dated 02/22/2025, was the only nurse progress note in Resident #27's Hospice Binder. The DON confirmed there should have been one note per week in the resident's hospice binder based on the hospice nurse's visit frequency of one visit per week. One visit per week, including the first visit conducted on 02/22/2025 equaled approximately 17 visits. The DON verbalized the concern with the lack of communication between the hospice agency and the facility was the facility would not know what care was provided the and what the hospice's plan was for upcoming care.<br><br>The facility policy titled Area of Focus: Hospice reviewed 11/19/2024, documented the IDT ensured communication between the facility and hospice. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, clinical record reviews, and document reviews, the facility failed to ensure the environment was free from accident hazards by not assessing and addressing the risk of entrapment for 1 of 24 sampled residents (Resident #270). The resident's bed was positioned with the right side pushed up against an air conditioning unit, leaving a gap of approximately six to eight inches between the mattress and the window and wall. This deficient practice had the potential to result in serious injury, including entrapment, by placing the resident at risk for preventable harm.<br><br>Findings include:<br><br>Resident #270<br><br>Resident #270 was admitted to the facility on [DATE], with diagnoses including acute diastolic heart failure, muscle weakness, and cognitive communication deficit.<br><br>On 06/24/2025 at 10:06 AM, Resident #270 was in bed and the right side of the resident's bed was pushed up against the air conditioning unit with approximately six to eight inches between the upper right side of the resident's mattress and the window and wall, and the headboard was approximately 2 feet away from the wall.<br><br>On 06/25/2025 at 9:12 AM, the bed of Resident #270 was still in the same position with the lower part of the right side of the bed pushed up against the air conditioning unit and a gap of approximately six to eight inches between the upper right side of the mattress and window and wall. The headboard of the bed was approximately 2 feet away from the wall.<br><br>On 06/25/2025 at 11:53 AM, the Registered Nurse for Resident #270 verbalized the resident's bed was pushed up closer to the wall and the headboard was away from the wall. The RN was unsure if the resident had been assessed to determine the resident's risk for entrapment.<br><br>The clinical record for Resident #270 lacked an assessment to determine if the resident was at risk of entrapment.<br><br>On 06/25/2025 at 2:02 PM, the Director of Nursing (DON) verbalized a resident's bed should never be up against a wall as it could be considered a restraint. The DON explained the expectation was for a resident's bed to have the headboard up against the wall and enough space to safely walk around the bed on both sides. The DON confirmed the resident did not have an entrapment risk assessment and the proximity of the resident's bed to the wall and window created a potential danger of the resident's head becoming trapped and could lead to strangulation.<br><br>The Facility's policy titled Incident and Reportable Event Management, reviewed 09/25/2024, documented the facility to the best of its ability strives to provide an environment free from accident hazards over which the facility had control and provides supervision and assistive devices to each resident to prevent avoidable accidents. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Resident #9<br><br>Resident #9 was admitted to the facility on [DATE], with a principal diagnosis of pneumonia due to other gram-negative bacteria.<br><br>Resident #9's Minimum Data Set 3.0 (MDS) assessment dated [DATE], section H (Bladder and Bowel) documented the following:<br><br>-A trial of a toileting program had not been attempted.<br><br>-The resident was always incontinent of bladder.<br><br>-The resident was always incontinent of bowel.<br><br>-A toileting program was not being used to manage the resident's bowel incontinence.<br><br>Resident #9's evaluation for bowel and bladder training dated 05/21/2025, documented the resident was a candidate for toileting and timed or scheduled voiding.<br><br>On 06/26/2025 at 2:13 PM, the Director of Nursing (DON) verbalized the purpose of a bowel and bladder program was to increase the continence level of the residents. The DON explained the bowel and bladder evaluation was completed upon admission to determine the resident's continence status. Once the resident's continence status was determined the evaluation was completed and the score would determine the interventions appropriate for the resident. When the resident was a candidate for toileting, timed or scheduled voiding, the intervention used was to round on the resident every two hours.<br><br>The DON confirmed Resident #9 was a candidate for toileting, timed or scheduled voiding, lacked person centered interventions and was unable to determine if the intervention of round every two hours was appropriate or an effective intervention for Resident #9. The DON was unable to determine if the resident's continence level changed during their stay in the facility.<br><br>The facility policy titled Bowel and Bladder Program, issued 09/24/2024, documented the facility would ensure a resident admitted with bladder incontinence received appropriate treatment and services to restore as much normal bladder function as possible.<br><br>Cross reference tag F656<br><br>Based on interview, clinical record review, and document review the facility failed to ensure 1) results of evaluations for bowel and bladder retraining were used to select resident-specific interventions intended to maintain and/or restore normal bowel and/or bladder function to the extent possible and 2) the interventions were documented, offered, and evaluated for effectiveness for 2 of 24 sampled residents (Resident #9 and #54). This deficient practice had the potential to result in decline in residents' continent status and cause embarrassment, social isolation, and decreased self-confidence.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Findings include:<br><br>Resident #54<br><br>Resident #54 was admitted to the facility on [DATE], with diagnoses including encounter for surgical aftercare following surgery on the digestive system and acute (reversible) ischemia of small intestine, extent unspecified.<br><br>On 06/24/2025 at 10:14 AM, Resident #54 verbalized the resident often had loose stool and was incontinent of bowel. The resident required staff assistance to clean up after each incontinent episode and the resident worried about going to appointments due to the resident not knowing when the resident was going to have a bowel movement. Resident #54 recalled the resident had asked facility staff about how to manage the resident's loose stool and had not heard back.<br><br>Resident #54's MDS assessment dated [DATE], section H (Bladder and Bowel) documented the following:<br><br>-A trial of a urinary toileting program had not been attempted.<br><br>-The resident was frequently incontinent of urine.<br><br>-The resident was frequently incontinent of bowel.<br><br>-A toileting program was not being used to manage the resident's bowel incontinence.<br><br>An Evaluation for Bowel and Bladder Training dated 06/07/2025, documented Resident #54 received a score of 14. The section titled Instructions/Scoring indicated a score of 14 equated to candidate for toileting, timed or scheduled voiding. The section titled Scoring on Admission/Quarterly documented if the score was 0-14 upon admission to complete the Urinary Incontinence Tool.<br><br>Resident #54's Urinary Incontinence Tool dated 06/07/2025, documented the following:<br><br>-The resident had stress incontinence.<br><br>-Physical assistance was required for toileting.<br><br>-The resident used a bed pan.<br><br>-The resident was unable to hold urine for more than a few minutes.<br><br>-Risk factors/complications included impaired mobility, abdominal/urologic surgery, diabetes, and pain.<br><br>Item C2 (List any medications which may affect urinary incontinence such as anticholinergics, sedatives/hypnotics, diuretics, calcium channel blockers, beta blockers, over the counter, cold remedies, herbals, etc.) was left blank.<br><br>Sections D (Lab Testing and results), E (Cognitive/Behavior Patterns Associated with Ability to Retrain), F (Referral Needs), and G (Additional Comments) were left blank.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #54's Order Summary Report documented the following physician orders:<br><br>-Furosemide tablet 40 milligrams (mg), give one tablet by mouth one time a day for edema. The start date was 06/16/2025.<br><br>-Metoprolol Succinate Extended Release (ER) 25 mg, give one tablet by mouth one time a day for hypertension. The start date was 06/07/2025.<br><br>Resident #54's Care Plan included the following:<br><br>-Focus: Bowel Incontinence. Goal: Resident would have no skin breakdown related to bowel incontinence. Interventions included assist with toileting as needed and pericare as needed. The date initiated was 06/08/2025.<br><br>-Focus: Urinary Incontinence. Goal: Resident would have no skin breakdown related to urinary incontinence. Interventions included assist with toileting as needed and pericare as needed. The date initiated was 06/08/2025.<br><br>On 06/25/2025 at 9:08 AM, a Certified Nursing Assistant (CNA) verbalized Resident #54 was incontinent of both bowel and bladder. The CNA explained staff performed rounds on residents every three hours however Resident #54 did not like to get up to the restroom. The CNA verbalized Resident #54 was able to get up with a walker and assistance from a staff member. The CNA verbalized the training provided to the CNA related to the facility's continence program included being instructed to toilet residents every two hours to try to keep them dry.<br><br>On 06/25/2025 at 9:13 AM, a Registered Nurse (RN) verbalized Resident #54 was incontinent of both bowel and bladder. The RN explained it was the facility's policy to check residents every two hours to see if the resident was soiled and needed to be changed however, staff often had a lot of residents, resulting in rounds being completed every 2-4 hours. Interventions being used to improve or maintain continence for Resident #54 were limited to asking the resident if the resident had a bowel movement.<br><br>On 06/26/2025 at 2:13 PM, the DON explained the facility had a toileting program which included completing a questionnaire upon admission, toileting residents every two hours, and checking residents for soiling. The questionnaire was documented in a bowel and bladder assessment in the facility's electronic medical record system. The intent of the program was to help residents remain continent or to become continent. The DON explained it would take a few days of a CNA working with a resident to determine potential treatments and routines, which were specific to the resident, to manage incontinence. The treatments and routines were communicated between CNAs during shift-to-shift report. The DON verbalized the DON was not aware of or familiar with the Urinary Incontinence Tool, when it would be completed, and how it would be used.<br><br>The DON explained nurses were responsible to oversee the management of a resident's incontinence, put the interventions to be used on the resident's care plan, and to direct the CNA on what the interventions were. The DON confirmed interventions should be resident-specific. Interventions to manage incontinence were assessed for effectiveness if a resident had a change such as when the resident had a urinary tract infection or if the resident had a catheter.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/26/2025 at 2:46 PM, the DON acknowledged Resident #54's Evaluation for Bowel and Bladder Training indicated the resident was a candidate for toileting, timed or scheduled voiding. The DON confirmed Resident #54's Care Plan and clinical record lacked documentation of resident-specific interventions to promote or maintain continence, offering and/or implementation of the interventions, and reassessment of the interventions for effectiveness.<br><br>The facility document titled Lippincott procedures - Bowel Training, revised 11/18/2024, documented fecal incontinence could lead to embarrassment, social isolation, decreased self-confidence, and depression, resulting in a lower quality of life. Treatments for fecal incontinence would begin conservatively and would be tailored to the resident's symptoms. Implementation of bowel training included assessment of the resident, collaboration with the resident to set a time for daily bowel movements which fit the resident's schedule, educating the resident regarding nutrition and adequate fluid intake, administration of medications if necessary, and documentation. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review, the facility failed to ensure a resident with a known history of significant weight loss was monitored for further weight loss upon readmission to the facility for 1 of 24 sampled residents (Resident #74). This deficient practice had the potential to result in serious health complications for the resident.<br><br>Findings include:<br><br>Resident #74<br><br>Resident #74 was admitted to the facility on [DATE] and readmitted on [DATE] after transferring to the hospital on [DATE], with diagnoses including enterocolitis due to clostridium difficile, cognitive social or emotional deficit following cerebral infarction and type 2 diabetes mellitus.<br><br>A Weight Summary for Resident #74 documented the resident weighed 181.4 pounds (lbs) on 04/11/2025 and weighed 168.0 lbs on 05/10/2025 indicating a significant weight loss of 13.4 lbs or 7.39 percent (%) body weight loss.<br><br>The Weight Summary documented the resident's weight obtained on 5/30/2025, was 156.7lbs. This indicated the resident had a severe weight loss of 11 lbs or 6.5% body weight loss from the facility's last documented weight obtained on 5/10/2024.<br><br>On 06/30/2025 at 3:20 PM, the Director of Nursing (DON) verbalized the resident was recently readmitted and should have a weight taken on readmission and then weekly weights for four weeks. The DON confirmed the RD had been aware the resident had a severe weight loss prior to the resident's hospitalization in May 2025 and it would be important to continue to monitor the resident for further weight loss to identify the cause of the resident's weight loss and implement interventions as needed.<br><br>The DON confirmed the facility policy was to weigh a resident upon admission and then continue to weigh the resident weekly for four weeks. The DON confirmed the facility did not have documented weekly weights for the resident after the resident was readmitted to the facility on [DATE].<br><br>The facility policy titled Resident at Risk Policy, revised 09/24/2024, documented residents newly admitted to the facility were weighted weekly for the first four weeks after admission to establish baseline weight and stability. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review and document review the facility failed to determine and document a resident's tolerable level of pain and administer pain medication according to a physician's order for 1 of 24 sampled residents (Resident #223). This deficient practice had the potential for unrelieved pain, discomfort, and inadequate pain management.<br><br>Findings include:<br><br>Resident #223<br><br>Resident #223 was admitted to the facility on [DATE], with diagnoses including encounter for surgical aftercare following surgery on the circulatory system and chronic pain syndrome.<br><br>On 06/24/2025 at 9:05 AM, Resident #223 was lying in the resident's bed. The resident verbalized the resident had chronic pain and regularly took pain medication at home to manage the pain however, facility was not providing the same amount of pain medication the resident used at home. The resident verbalized the facility nurse had declined to administer the resident's usual dose of pain medication due to the resident's Blood Pressure (BP) being low however the facility continued to administer medication to lower the resident's blood pressure. The resident reported having current abdominal and back pain, the pain was rated ten on a 0-10 scale, and the pain prevented the resident from walking.<br><br>During the interview a Registered Nurse (RN) entered the resident's room, verbalized the RN had been informed the resident needed pain medication, and checked the resident's BP. The RN explained to the resident the RN could not give two tablets of pain medication due to the BP reading of 90/59 and asked if the resident was ok with receiving one tablet. Resident #223 verbalized the resident was not ok with receiving one tablet. The RN verbalized the RN would discuss the resident's pain with the physician.<br><br>Resident #223's Minimum Data Set 3.0 (MDS) assessment dated [DATE], Section J, documented the resident had received As Needed (PRN) medications within the previous five days, the resident had occasional pain, the pain occasionally effected sleep, and occasionally interfered with therapy and day-to-day activities.<br><br>Resident #223's Order Summary Report included the following physician orders:<br><br>-PainAD Assessment: Location of pain: 1) generalized, 2) back, 3) leg, 4) head. Attempt non-med interventions prior to administering PRN pain medications: 1) calm/quiet environment, 2) reposition, 3) redirection, 4) elevate extremities. Every shift, do not arouse from sleep. Do not exceed 3,000 milligrams (mg) Acetaminophen in a 24 hours period from all sources. Document pain level, location of pain, and intervention used.<br><br>-Acetaminophen tablet 325 mg, give two tablets by mouth every four hours as needed for pain scale 1-3.<br><br>(continued on next page) |

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| Life Care Center of Reno | 445 W. Holcomb Lane<br>Reno, NV 89511 |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Oxycodone Hydrochloride (HCl) oral tablet 5 mg, give one tablet by mouth every four hours as needed for pain scale 4-6.<br><br>-Oxycodone HCl oral tablet 5 mg, give two tablets by mouth every four hours as needed for pain scale 7-10.<br><br>Resident #223's June 2025 Medication Administration Record (MAR) documented Oxycodone HCl oral tablet 5 mg, give one tablet by mouth every four hours as needed for pain scale 4-6. The order date was 06/23/2025. Documented administrations included the following:<br><br>-06/24/2025 at 9:15 AM, the pain level was ten.<br><br>-06/26/2025 at 2:15 AM, the pain level was seven.<br><br>-06/27/2025 at 5:25 AM, the pain level was seven.<br><br>Resident #223's Care Plan documented the following focuses, goals and interventions:<br><br>-Focus: Resident at risk for rehospitalization due to congestive heart failure, atrial fibrillation, pulmonary embolism, obesity, and chronic pain. Interventions included: Provide medications as ordered, interdisciplinary team to meet as needed to discuss resident's condition and interventions. The date initiated was 06/20/2025.<br><br>-Focus: Resident is on pain medication therapy related to congestive heart failure, pulmonary embolism, and bilateral lower extremity edema. Goal: The resident would be free of any discomfort or adverse side effects from pain medication. Interventions included: Administer analgesic medications as ordered by physician. Observe for side effects and effectiveness every shift. The date initiated was 06/22/2025.<br><br>-Focus: Resident expresses pain/discomfort related to chronic pain disorder. Goal: The resident will express pain relief. Interventions included: Educate resident regarding pain management, evaluate effectiveness of pain interventions, pain medications as ordered. The date initiated was 06/20/2025 and the revised date was 06/22/2025.<br><br>Resident #223's clinical record lacked documentation of an assessment and determination of the resident's tolerable level of pain.<br><br>On 06/25/2025 at 2:24 PM, the RN verbalized residents' pain was assessed using a 0-10 scale when the resident was admitted , then every four hours for three days, then every shift. The RN did not provide a response when asked how the facility determined a resident's tolerable level of pain. The RN explained staff would reassess a resident's pain one hour after administering pain medication. The RN would determine if a pain management intervention was effective if a resident was sleeping, conversing, or able to participate in therapy at the time of the reassessment. If an intervention was not effective, the RN would attempt another intervention such as change in position, redirection, or another medication.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The RN verbalized the RN was familiar with Resident #223 and confirmed the resident complained of pain. The pain was chronic and generalized. The RN recalled when the RN returned to work on 06/23/2025, the RN got report from the night shift nurse the resident's BP had been low. Due to the low BP, the night shift nurse had not administered two tablets of pain medication to the resident. The RN recalled the RN checked Resident #223's BP the morning of 06/23/2025, the BP remained low. After contacting the resident's physician, the resident's pain medication order was changed and a diuretic was discontinued. The resident was now receiving Oxycodone 10 mg every four hours and the pain was much better.<br><br>On 06/30/2025 at 9:59 AM, the Director of Nursing (DON) explained all facility staff members were part of the facility's approach to pain management. Certified Nursing Assistants (CNAs) would ask the residents about pain, nurses would watch for pain and administer pain medication, the physician asked about pain during exams, and patients told staff when they were experiencing pain. The DON verbalized pain medication was to be administered per the physician's order. If the physician's order specified a pain scale for which the medication was to be administered, the DON denied it would be appropriate to administer the medication if the resident reported a pain level which did not fall within the ordered pain scale.<br><br>The DON explained a tolerable level of pain was resident driven as every person's pain tolerance was different. A resident's tolerable level of pain was determined upon admission and the process included talking to rehab/therapy staff and talking to the resident. For example, if a resident's tolerable pain level was three and the resident was not able to get out of bed at a level five, the facility would want to keep the resident's pain lower to allow the resident to work with therapy. The DON verbalized a resident's tolerable level of pain and the assessment completed to determine the tolerable level should be documented in the resident's record. The DON verbalized the DON thought it would be documented in a progress note so the information was able to be viewed by all staff.<br><br>The DON affirmed the DON was familiar with Resident #223 and verbalized the resident was having issues with pain. The DON explained the resident was alert and oriented and was able to rate pain on a 0-10 scale. The DON verbalized the resident had Oxycodone ordered, 5 mg every four hours for pain rating 4-6 and 10 mg for pain rating 7-10. The DON reviewed Resident #223's MAR and confirmed the MAR documented one tablet of Oxycodone 5 mg was administered to the resident on 06/24, 06/26, and 06/27/2025 despite the pain rating being greater than six. The DON confirmed administering one tablet of Oxycodone 5 mg for a pain rating from 7-10 was not following the physician's order. The DON verbalized if a resident's BP was really low, a nurse may decide not to administer the Oxycodone. The DON's expectation would be for the nurse to notify the physician to see if there was anything else the facility could do to manage the resident's pain and enter a progress note to document the notification as well as any orders received. The DON reviewed Resident #223's clinical record and denied the clinical record included documentation of the resident requesting one tablet of Oxycodone, staff contacting the physician regarding the resident's BP, approval to administer one tablet, or request for additional/alternate orders to managed the resident's pain.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility policy titled Pain Assessment and Management, revised 04/22/2025, documented the facility was to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. To assess pain, the facility would utilize the Lippincott procedures: Pain assessment, long-term care. Based on the assessment, the facility, in collaboration with the physician and the resident would develop, implement, monitor, and revise as necessary interventions to prevent or manage each individual resident's pain, beginning at admission. The facility would address/treat underlying causes of pain to the extent possible, including developing and implementing both non-pharmacological and pharmacological interventions/approaches to pain management.<br><br>The facility document titled Lippincott procedures: Pain assessment, long-term care, revised 05/19/2025, documented it was crucial for nurses to assess and address residents' pain because residents were more likely to return to baseline with early recognition and treatment of pain. Inadequate treatment of pain is associated with many adverse outcomes among long-term care residents, including falls, disrupted sleep and eating, and impaired mobility. The assessment, identification, and treatment of pain were important components of residents' care plan and an ethical part of nursing care. Assessment of pain included working with the resident to determine a tolerable pain level which provided enough relief to enable the resident to participate in personal care. Staff were to try to maintain the resident's pain at the tolerable level or lower, reassess and respond to the resident's pain by evaluated response to treatment and progress toward pain management goals. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interview and document review the facility failed to maintain completed dialysis communication forms for 3 of 24 sampled residents (Resident #2, #85 and #61). This deficient practice had the potential to result in a lack of critical information shared between the facility and the dialysis provider with the potential to have lead to delays or errors in care, adversely having affected resident health and safety.<br><br>Findings include:<br><br>Resident #2<br><br>Resident #2 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including end stage renal disease and dependence on renal dialysis.<br><br>A physician's order dated 03/21/2025. documented Resident #2 was to receive dialysis treatment at a dialysis center, every Tuesday, Thursday and Saturday for end stage renal disease.<br><br>Resident #2's clinical record lacked documented evidence of a completed dialysis communication transfer form for the following dates:<br><br>-03/29/2025, Saturday<br><br>-04/01/2025, Tuesday<br><br>-04/05/2025, Saturday<br><br>-04/12/2025, Saturday<br><br>-04/24/2025, Thursday<br><br>-04/26/2025, Saturday<br><br>-04/29/2025, Tuesday<br><br>-05/01/2025, Thursday<br><br>-06/26/2025, Thursday<br><br>-06/28/2025, Saturday<br><br>Resident #85<br><br>Resident #85 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including end stage renal disease and dependence on renal dialysis.<br><br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A physician's order dated 04/30/2025 documented Resident #85 was to receive dialysis treatment at a dialysis center, every Monday, Wednesday and Friday for end stage renal disease.<br><br>Resident #85's clinical record lacked documented evidence of a completed dialysis communication transfer form for the following dates:<br><br>-05/21/2025, Wednesday<br><br>-05/23/2025, Friday<br><br>-05/28/2025, Wednesday<br><br>-06/11/2025, Wednesday<br><br>-06/23/2025, Monday<br><br>-06/25/2025, Wednesday<br><br>-06/27/2025, Friday<br><br>On 06/30/2025 at 4:30 PM, the Director of Nursing (DON), confirmed Resident #2 and Resident #85's clinical records lacked the completed dialysis communication transfer forms for the above dates.<br><br>The DON verbalized the expectation was for nursing staff to complete the communication form before the resident was transported to the dialysis center and upon the resident's return. The DON verbalized nursing staff should have contacted the dialysis center if the form was not returned with the resident or if the form was incomplete.<br><br>The facility policy titled, Hemodialysis Offsite Policy, with a reviewed date of 09/06/2024, documented the facility was to have ongoing communication and coordination between the facility and the dialysis center. Nursing staff would initiate the pre/post dialysis communication form and upon the resident's return, complete and maintain the form.Resident #61<br><br>Resident #61 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including end stage renal disease and dependence on renal dialysis.<br><br>Dialysis Orders:<br><br>Resident #61's Order Summary Report did not include an order for renal dialysis.<br><br>On 06/30/25 at 11:03 AM, the DON confirmed Resident #61's Order Summary Report did not include an order for dialysis and did not include an order for care or assessment of the access port site. The DON confirmed without the order to assess for thrill/bruit, the assessment need would not be entered onto the Treatment Administration Record (TAR) and the resident's nurse would not be alerted to do the assessment and would not be able to document the assessment on the TAR.<br><br>Dialysis Communication<br><br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A physician's order entered on 06/30/2025, documented Resident #61 was to receive dialysis treatment at a dialysis center, every Tuesday, Thursday and Saturday for end stage renal disease.<br><br>Resident #61's clinical record lacked documented evidence of a completed dialysis communication transfer form during April 2025 for the following dates:<br><br>-04/03/2025, Thursday<br><br>-04/05/2025, Saturday<br><br>-04/15/2025, Tuesday<br><br>-04/22/2025, Tuesday<br><br>-04/24/2025, Thursday<br><br>Resident #61's clinical record lacked documented evidence of a completed dialysis communication transfer form during May 2025 for the following dates:<br><br>-05/06/2025, Tuesday<br><br>-05/10/2025, Saturday<br><br>-05/13/2025, Tuesday<br><br>-05/22/2025, Thursday<br><br>-05/27/2025, Tuesday<br><br>-05/29/2025, Thursday<br><br>Resident #61's clinical record lacked documented evidence of a completed dialysis communication transfer form during June 2025 for the following dates:<br><br>-06/14/2025, Saturday<br><br>-06/19/2025, Thursday<br><br>-06/26/2025, Thursday<br><br>-06/28/2025, Saturday<br><br>On 06/30/2025 at 10:22 AM, a Registered Nurse (RN) verbalized when a resident returned from dialysis, the resident would be assessed to ensure the resident was stable and the resident's needs were being met. The resident's nurse would place the dialysis communication form in the resident's hard (paper) chart.<br><br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/30/2025 at 10:22 AM, an RN verbalized when a resident returned from dialysis, the resident would be assessed to ensure the resident was stable and the resident's needs were being met. The resident's nurse would place the dialysis communication form in the resident's hard (paper) chart.<br><br>On 06/30/2025 at 11:13 AM, the DON confirmed Resident #61 had dialysis on Tuesday, Thursday, and Saturday each week and a dialysis communication form should have been placed in the resident's hard chart following each day of dialysis.<br><br>On 06/30/2025, at 11:59 AM, the DON confirmed Resident #61's hard chart did not included a dialysis communication form for each day the resident had received dialysis. The DON explained the missing communication had the potential for the resident's care concerns to not be addressed, including any new orders resulting in the resident not receiving the necessary care.<br><br>On 06/30/2025 at 4:47 PM, the Regional Clinical Director (RDC) verbalized the facility was looking for additional communication notes and reached out to the dialysis agency. The RDC confirmed it was the responsibility of the facility to ensure dialysis communication notes were received following each dialysis visit and scanned into the residents' chart.<br><br>On 07/01/2025 at 8:36 AM, the RDC provided additional dialysis communication forms and explained the forms were found in various places of the resident's clinical record. The RDC confirmed the dialysis communication forms provided were inclusive of all communication available in the residents chart, including the resident's hard chart and electronic health record (EHR). The concern with the lack of communication between the facility and dialysis was the potential for a lack of continuity of care.<br><br>The facility policy titled, Hemodialysis Offsite Policy, with a reviewed date of 09/06/2024, documented the facility was to have ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments and have ongoing communication and coordination between the facility and the dialysis center. Nursing staff would initiate the pre/post dialysis communication form and upon the resident's return, complete and maintain the form. A physician's order was to be established for the amount of time required for dialysis. |

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| F 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review, the facility failed to ensure all of a resident's medications were signed and dated during provider visits for 1 of 24 sampled residents (Resident #421). This deficient practice had the potential to result in medication errors, compromising the resident's health and safety.<br><br>Findings include:<br><br>Resident #421<br><br>Resident #421 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including bipolar disorder, depression, anxiety disorder unspecified, and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.<br><br>Resident #421's physician's orders dated 06/18/2025, documented the following:<br><br>-Acetaminophen tablet 325 milligram (mg). Give two tablets by mouth every four hours as needed for temperature above 101not to exceed three gram (gm)/24 hours.<br><br>-Acetaminophen tablet 325 mg. Give two tablets by mouth every four hours as needed for pain scale one to three. Acetaminophen not to excess 3 gm/24 hours.<br><br>-Dulcolax Suppository 10 mg (Bisacodyl). Insert 10 mg rectally as needed for constipation if no results from Milk of Magnesia daily.<br><br>-Fleet Enema 7-19 gm/118 milliliter (ml) (Sodium Phosphates). Insert one application rectally as needed for constipation if no results from suppository. May be given daily.<br><br>-Full Code.<br><br>-HS (at bed time) snack in the evening. Document percentage consumed.<br><br>-May crush medications unless contraindicated.<br><br>-May have podiatry consult as needed.<br><br>-May participate in planned activities programs as tolerated.<br><br>-May use generic equivalents unless otherwise indicated.<br><br>-Milk of Magnesia Suspension 400 mg/5 ml (Magnesium Hydroxide). Give 30 ml by mouth as needed for no bowel movement in three days. May give daily.<br><br>-Occupational Therapy evaluation and treatment as indicated one time only for seven days.<br><br>(continued on next page) |

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| F 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -PainAD Assessment:<br><br>Location of pain: 1. Abdomen 2. Back 3. General<br><br>Attempt non-med interventions prior to administering as needed pain medications:<br><br>1.<br><br>Reposition<br><br>2.<br><br>Redirection<br><br>3.<br><br>Pillows<br><br>4.<br><br>Ice every shift. Do not arouse from sleep. Do not excess 3, 000 mg Acetaminophen in a 24 hour period from all source. Document pain level, location of pain number (LOC#), and number of intervention used (INT#).<br><br>-Physician has reviewed and agrees with the plan of care (see signature).<br><br>-Pressure reducing cushion in wheelchair. Confirm every shift.<br><br>-Pressure relieving mattress on bed. Confirm every shift.<br><br>-Physical Therapy evaluation and treatment as indicated one time only for seven days.<br><br>-Read and document results of PPD one time only until 06/22/2025 23:59. Step 1: Document results on immunization record and one time only until 06/30/2025 23:59. Document results on immunization record.<br><br>-Regular diet. Easy to chew texture, this consistency.<br><br>-Skin protective ointment to perianal area at each brief change. Confirm every shift.<br><br>-Speech Therapy evaluation and treatment as indicated one time only for history of esophageal CA for seven days.<br><br>- Tuberculin PPD Solution five unit/0.1 ml. Inject 0.1 ml intradermally one time only for TB prevention until 06/19/2025 23:59. Step 1-Document on immunization record and inject 0.1 ml intradermally one time only for TB prevention until 06/27/2025 23:59. Step 2-document on immunization record.<br><br>(continued on next page) |

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| F 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Does resident experience signs and symptoms of shortness of breath (SOB) when lying flat or avoid lying flat due to signs and symptoms of SOB? (increased respiratory rate, pursed lip breathing, a prolonged expiratory phase, audible respirations, gasping for air, interrupted speech pattern, use of accessory muscles, anxiety, restlessness etc.) Monitor every shift for aftercare following feeding tube placement related to Chronic Obstructive Pulmonary Disease, unspecified. Document yes or no.<br><br>-Enteral Feed order every shift head of bed elevated at lease 30 degrees.<br><br>-Enteral Feed order every day shift. Asses the tube exit site for new or increasing pain and signs of skin breakdown, redness, edema, leakage, induration, bleeding, and wear and tear.<br><br>-Enteral Feed order every shift. If Jejunostomy tube bumper not snugly against the skin, hold tube firmly with one hand and slide the bumper against the ABD with the other. Do not place bumper too tightly against skin as it will result in skin breakdown.<br><br>-Enteral Feed order every shift. Verify position of external bumper on PEG tube. Bumper to remain snugly flush against ABD with dry slit gauze placed underneath.<br><br>-Incentive Spirometer as needed for after care following feeding tube placement related to chronic obstructive pulmonary disease, unspecified. Document lung sounds, respiratory rate ,and SpO2 before and after and number of minutes administered.<br><br>-lung sounds (LS) =<br><br>-C-Clear<br><br>-W- wheezing<br><br>-R-Rhonchi<br><br>-CR-Crackles<br><br>-D-Diminished and four times a day for aftercare following feeding tube placement related to chronic obstructive pulmonary disease, unspecified, for two weeks document lung sounds, respiratory rate, and SpO2 rate before and after and number of minutes administered.<br><br>-lung sounds (LS) =<br><br>-C-Clear<br><br>-W- wheezing<br><br>-R-Rhonchi<br><br>-CR-Crackles<br><br>-D-Diminished<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 295050 | A. Building<br>B. Wing | 07/01/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Life Care Center of Reno | 445 W. Holcomb Lane<br>Reno, NV 89511 |

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| F 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Monitor for signs and symptoms of bleeding; including black tarry stools, bleeding gums, bruising/nose bleed related to antiplatelet use every shift for antiplatelet use. Document + if signs and symptoms present and - if signs and symptoms not present.<br><br>-Opioid medication: side effects: Observe for tolerance, physical dependence, increased sensitivity to pain, constipation, nausea, vomiting and dry mouth, respiratory depression, sleepiness, dizziness and/or confusion, depression and itching, and sweating. Every shift document + if signs and symptoms present and - if signs and symptoms not present. If side effects are noted, notify MD and enter progress notes in point click care.<br><br>-Hypoglycemia protocol: Resident alert-give eight ounces (oz) orange juice every 10 minutes as needed for fasting blood sugar (FSBS) less than 70. Recheck in ten minutes. If FSBS remains less than 70 repeat orange juice and contact MD.<br><br>-If fingerstick blood sugar less than 70 and resident not alert or greater than 400 contact MDS/APN as needed for diabetes mellitus.<br><br>-Monitor for signs and symptoms of hypoglycemia or hyperglycemia every shift.<br><br>-Aspirin tablet chewable 81 mg. Give one tablet enterally in the morning related to atherosclerotic heart disease of native coronary artery without angina pectoris.<br><br>-Gabapentin capsule 300 mg. Give one capsule enterally three times a day for neuropathic pain.<br><br>-Methadone HCl oral tablet 10 mg (Methadone HCl). Give four tablets by mouth in the morning for chronic pain.<br><br>-Omeprazole tablet delayed release 20 mg. Give two tablets by mouth at bedtime for GERD.<br><br>-Propranolol HCl oral tablet 20 mg (Propranolol HCL). Give one tablet enterally two times a day for hypertension. Hold for SBP less than 100 and heart rate less than 60.<br><br>-Quetiapine Fumarate oral tablet 50 mg (Quetiapine Fumarate). Give one tablet enterally at bedtime for bipolar disorder as evidenced by mood swings.<br><br>-Senna-Docusate Sodium oral tablet 8.6-50 mg (Sennosides-Docusate Sodium). Give one tablet enterally two times a day for constipation. Hold for loose stool.<br><br>-Sertraline HCl oral tablet 100 mg (Sertraline HCl). Give one tablet enterally two times a day for depression as evidenced by sad facial expression.<br><br>-Zonisamide oral capsule 100 mg (Zonisamide). Give one capsule enterally in the morning for seizure prophylaxis.<br><br>-Depakote Sprinkles capsule sprinkle 125 mg (Divalproex Sodium). Give four capsules enterally in the morning for seizure prophylaxis.<br><br>(continued on next page) |

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| F 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Mybetriq oral tablet extended release 24 hour 50 mg (Mirabegron). Give one tablet by mouth in the morning for overactive bladder.<br><br>-Admit to Life Care Center of Reno.<br><br>-Admit to Skilled Medicare A services.<br><br>-Admit to skilled insurance services.<br><br>-Enteral Feed order every shift. Jeity 1.5 at 50ml/hour times 16 hours via pump from 1400 to 0600. Flush with 150 ml purified water every four hours and in the afternoon turn on tube feed and in the morning turn off tube feeding.<br><br>-Easy to chew, small portions, water only liquid, every shift for dysphagia and history of esophageal CA<br><br>-By mouth diet for pleasure feeds only. Avoid liquids, ice chips ok. May have small single bites of soft solid food every shift for dysphagia and history of esophageal CA.<br><br>-Nursing: clean J tube site with NS, pat dry, apply 4x4 drain gauze sponge / 4 X 4 border gauze daily and as needed every 24 hours.<br><br>-Enhanced barrier precautions secondary to J-tube every shift for J-tube.<br><br>Resident #421's history and physical was dated 06/20/2025, and was completed at the facility.<br><br>Resident #421's physician's orders lacked a physician's signature and date during the physicians visit on 06/20/2025, indicating all resident medications were authorized for administration to the resident.<br><br>On 06/25/2025 at 4:39 PM, the Regional Director of Clinical Services confirmed the resident was being administered medications without proper physician authorization to do so and verbalized the Physician was asked to sign off on all physician's orders electronically for all residents.<br><br>On 06/25/2025 at 4:39 PM, the Registered Nurse (RN) confirmed all of the physician's orders and verbalized physician's orders documented a communication method to the pharmacy, and as a result, the physician's orders were valid.<br><br>On 06/26/2025 at 2:25 PM, the Physician explained all physician's orders were put into the resident's electronic hard chart by a nurse and the Physician would then need to access the electronic system and sign all physician's orders. The Physician confirmed Resident #421's physician's orders were not authorized with a signature and date and verbalized it was the Physician's fault why the orders were not signed and dated.<br><br>A Performance Requirements and Practice Agreement, signed and dated by the Physician on 03/16/2017, documented the physician would assess the patient's condition and progress, review, and sign orders in the patient's medical record at the time of each visit.<br><br>(continued on next page) |

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| F 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility policy titled Authorization and Communication of Orders, last revised 07/01/2024, documented the facility should not administer medications or biologicals except upon the order of a physician/prescriber lawfully authorized to prescribe and treat human illness. Orders should be signed with an actual written signature or by electronic means. Signature stamps could also be used as permitted. |

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| F 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide medically-related social services to help each resident achieve the highest possible quality of life.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review, the facility failed to ensure social services staff assessed the impact of a room relocation on the resident's psychosocial status for a resident with a room change per facility policy for 1 of 24 sampled residents (Resident #171). This deficient practice had the potential to result in avoidable psychosocial harm.<br><br>Findings include:<br><br>Resident #171<br><br>Resident #171 was admitted to the facility on [DATE], with a primary diagnosis of unspecified nondisplaced fracture of surgical neck of right humerus, subsequent encounter for fracture with routine healing.<br><br>A Resident Listing Report dated 06/22/2025, documented Resident #171 had a room change on 06/19/2025.<br><br>Resident #171's clinical record lacked documented evidence of an assessment completed by social services regarding the resident's room change.<br><br>On 06/23/2025 at 9:33 AM, Resident #171 verbalized approximately five days prior, the resident was evicted from their room in the other building of the same facility. The resident was told by facility staff not to speak to Resident #171's roommate and when they continued to speak, Resident #171 was moved to their new room. Resident #171 verbalized the resident did not want to move rooms as the resident was friends with their roommate.<br><br>On 06/25/2025 at 02:52 PM the Licensed Social Worker (LSW) verbalized being responsible for completing room change assessments; however, the LSW confirmed a room change assessment was not completed the night of Resident #171's room change on 06/19/2025. The LSW verbalized room change assessments were important to ensure residents were provided a choice in the room change.<br><br>The facility policy titled, Resident Room Relocation, reviewed 09/05/2024, documented the social services staff would assess the impact of room relocation on the resident's psychosocial status.<br><br>Cross reference with F559. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observation, interview, and document review the facility failed to ensure expired medications were removed from 2 of 3 medication carts inspected and a medication bottle was labeled with an expiration date in 1 of 3 medication carts inspected. This deficient practice had the potential to result in administration of expired medications, posing a risk to resident safety.<br><br>Findings include:<br><br>On 06/26/2025 at 11:30 AM, during an inspection of the station one front hall medication cart and in the presence of the Assistant Director of Nursing (ADON), the following items were found:<br><br>-One box of Cranberry capsules 240 milligrams (mg) with capsules remaining in the box. The expiration date printed on the box and capsule packaging was 01/2023.<br><br>-One box of Probiotic capsules with capsules remaining in the box. The expiration date printed on the box was 02/2025.<br><br>The ADON verbalized if the expiration date was listed as a month and year the item expired at the end of the month. The ADON confirmed the expiration dates printed on the boxes of Cranberry and Probiotic capsules had passed. The ADON placed both boxes of medication in the designated area in the medication storage room for destruction.<br><br>On 06/26/2025 at 12:06 PM, during an inspection of the station four medication cart and in the presence of a Registered Nurse (RN), the following items were found:<br><br>-One box of Probiotic capsules with capsules remaining in the box. The expiration date printed on the box was 02/2025.<br><br>-One bottle of ProSource Plus 15 grams (g) protein/ one fluid ounce. The expiration was not able to be read and appeared to have been rubbed off.<br><br>The RN confirmed the expiration date printed on the box of Probiotic capsules had passed and verbalized the capsules should have been removed from the cart. The RN confirmed the bottle of ProSource Plus lacked a legible expiration date and verbalized it was not appropriate to administer the medication to residents due to the nurse not being able to verify the expiration date of the medication. The RN placed both medications in the designated area in the medication storage room for destruction.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/26/2025 at 2:09 PM, the Director of Nursing (DON) verbalized medications were required to be labeled with the resident's name, frequency of administration, and an expiration date. It was important for the medication to be labeled with an expiration date to ensure the medication was still good to give to residents. The DON confirmed expired medications should be removed from medication carts and storage with active medications in storage rooms. The expired medications were to be removed immediately upon expiration. The DON verbalized if an expired medication was not removed from the medication cart, the medication could be administered to a resident by mistake. The DON explained nurses were supposed to always check medications prior to administration to ensure the expiration date had not passed however, sometimes the check did not occur.<br><br>The facility policy titled Disposal/Destruction of Expired or Discontinued Medication, revised 07/01/2024, documented the facility was to place all discontinued or outdated medications in a designated, secure location which is solely for discontinued medications or marked to identify the medications are discontinued and subject to destruction. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and document review, the facility failed to ensure 1) handwashing stations were in working order and stocked with soap and disposable gloves, 2) dry food was sanitarily stored, 3) a griddle's grease trap was maintained in clean working condition, and 4) a refrigerator was monitored for safe storage temperatures. This deficient practice had the potential to affect all residents in the facility by increasing the risk of infection and foodborne illnesses.<br><br>Findings include:<br><br>Kitchen Handwashing Station<br><br>On 06/22/2025 at 11:37 PM, the faucet controls of a hand sink in the primary kitchen dish room were in an active position; however, there was no water flow.<br><br>On 06/22/2025 at 11:37 PM, the Registered Dietician (RD) verbalized being unaware the hand sink was out of order and confirmed there was no water flow. The RD explained it was important hand sinks were in working order because staff must be able to sanitize their hands in a food prep environment.<br><br>On 06/26/2025 at 2:19 PM, the handwashing station in the café/gift shop was not stocked with soap and disposable hand towels.<br><br>On 06/26/2025 at 2:19 PM, the Dietary Manager (DM) confirmed there were no hand towels at the café/gift shop handwashing station.<br><br>On 06/26/2025 at 3:01 PM, a Certified Nursing Assistant (CNA) responsible for overseeing the café/gift shop confirmed there was no hand soap present at the café/gift shop handwashing station.<br><br>The facility policy titled, Safe Food Handling, revised 04/30/2025, documented associates would wash their hands in a handwashing sink in accordance with current food code guidelines immediately before work in the morning, after eating or drinking, during food preparation, before donning gloves, and after engaging in any other activities to contaminate hands.<br><br>The United States Food and Drug Administration 2022 Food Code, dated 01/23/2023, documented each handwashing sink would be provided with a hand cleaning liquid powder or bar soap and individual disposable towels or other hand drying device.<br><br>Dry Food Storage<br><br>On 06/22/2025 at 11:41 AM, a scoop was placed in a transparent lidded bin of rice cereal with the handle in contact with the cereal food.<br><br>On 06/22/2025 at 11:414 AM, the RD confirmed the scoop was inside the bin with the handle touching the rice cereal. The RD verbalized the scoop should not be in the bin as it risked contamination of the food.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 06/26/2025 at 2:19 PM, the DM verbalized food scoops should have place holders.<br><br>The facility policy titled, Food Safety, reviewed 05/01/2025, documented scoops would be stored in a manner to prevent contamination of food ingredients. Scoops would be stored outside of bins or placed in a holder on the side of the bin.<br><br>Grease Trap<br><br>On 06/22/2025 at 11:43 AM, charred grease was spread over the entire surface of the primary kitchen's griddle grease trap.<br><br>On 06/22/2025 at 11:43 AM, a [NAME] confirmed the grease trap was covered in charred grease. The [NAME] explained it was important to clean the grease trap often to prevent the grease from catching fire. The [NAME] verbalized cleaning the grease trap once a week.<br><br>On 06/22/205 at 11:43 AM, the RD confirmed the grease trap was covered in grease and verbalized being unsure how often they were meant to be cleaned.<br><br>On 06/26/2025 at 2:08 PM, the DM verbalized the grease traps should be cleaned once a week or more often depending on the grease buildup. The DM verbalized the facility did not keep a cleaning log for the griddle grease trap.<br><br>The facility policy titled, Safe Food Handling, revised 04/30/2025, documented all work surfaces, utensils and equipment were cleaned and sanitized appropriately after each use and if contaminated.<br><br>Refrigerator Log<br><br>On 06/26/2025 at 3:01 PM, the café/gift shop refrigerator lacked a temperature log.<br><br>On 06/26/2025 at 3:01 PM, the CNA responsible for overseeing the café/gift shop verbalized the facility had not yet begun monitoring the refrigerator as the café/gift shop was recently opened approximately two weeks prior. The CNA confirmed residents were served out of the café/gift shop and explained it was important to monitor the refrigerator temperatures to ensure temperature consistency when serving drinks to the residents.<br><br>On 06/30/2025, the DM verbalized refrigerator temperatures should be documented in the morning prior to opening the kitchen and at night prior to closing the kitchen. The DM explained temperature logs helped to ensure the refrigerator was running at a temperature to keep the food inside fresh.<br><br>The facility policy titled, Gift Shop Operation, reviewed 05/15/2025, documented snack shops would conform to all regulations relating to sanitation, refrigeration, food quality, and other rules relative to general dietary and kitchen services.<br><br>The facility policy titled, Food Safety, reviewed 05/01/2025, documented refrigerator temperatures were recorded at least twice daily on the refrigerator temperature log using an inside thermometer. |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Administer the facility in a manner that enables it to use its resources effectively and efficiently.<br><br>Based on observation, document review, and interview the facility failed to demonstrate effective administration by not ensuring the facility had a process for written notification of resident room changes and the facility's influenza (flu) and pneumonia (PNA) vaccination program included 1) screening residents for eligibility to receive the vaccines, 2) the provision of education related to the risk and benefits of the vaccines to residents and/or the resident's representative preventing the resident or the resident's representative from making an informed decision regarding the vaccines, 3) a process for determining/selecting the correct PNA vaccine for each resident per the Centers for Disease Control and Prevention (CDC) guidance. This failure resulted in substandard quality of care.<br><br>Findings include:<br><br>Room Changes<br><br>The facility lacked documented evidence 38 of 49 residents who experienced a room change while residing in the facility received written documentation of the reason for the room change was provided to the resident or the resident's representative.<br><br>Influenza Vaccine<br><br>The facility lacked documented evidence 38 of 38 residents eligible or potentially eligible to receive a flu vaccine were screened for eligibility to receive a flu vaccine and lacked documented evidence education related to the 2024/2025 flu vaccines was provided to the resident or the resident's representative.<br><br>Pneumonia Vaccine<br><br>The facility lacked documented evidence 38 of 38 residents eligible or potentially eligible to receive a PNA vaccine were screened for eligibility to receive a PNA vaccine and lacked documented evidence education regarding the PNA vaccine the resident was eligible to receive was provided to the resident or the resident's representative.<br><br>On 07/01/2025 at 1:47 PM, the Administrator explained the facility had identified issues regarding resident notification of room changes and resident influenza and pneumonia vaccines. The Administrator explained the process put in place for written notification of resident room changes was still being actively monitored and confirmed there were still ongoing issues with the notification of resident room changes. The Administrator verbalized the facility had no current action plan implemented for resident influenza and pneumonia vaccinations.<br><br>The Executive Directors job description, signed and dated 7/15/2024 by the Administrator, documented the Executive Director provides leadership and direction over all facility operations to provide quality patient care in accordance with all laws, regulation and facility standards.<br><br>Cross Reference with tags F559 and F883 |

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| F 0836<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, personnel record review, document review, and interview, the facility failed to ensure compliance with the State of Nevada Revised Statute (NRS) 449.174 related to fingerprinting and Nevada Automated Background System (NABS) clearance for an employee having access to a sampled resident's record (Resident #83). This deficient practice placed residents at risk from an employee not having completed all employment eligibility requirements.<br><br>Findings include:<br><br>Resident #83<br><br>Resident #83 was admitted to the facility on [DATE], with diagnoses including hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left non-dominant side, muscle weakness (generalized), difficulty in walking, not elsewhere classified, attention and concentration deficit following cerebral infarction, memory deficit following cerebral infarction, cognitive social or emotional deficit following cerebral infarction, type 2 diabetes mellitus without complications, encounter for surgical aftercare following surgery on the digestive system, paroxysmal atrial fibrillation, hyperlipidemia, unspecified, obstructive sleep apnea (adult), anxiety disorder, unspecified, gastrostomy status, depression, unspecified, essential (primary) hypertension, acute sialadenitis, and a history of falling.<br><br>On 06/25/2025 at 1:21 PM, the Administrator verbalized a corporation employee with a title of Medical Records Director (Non-Nurse), had been assisting with the coding of resident records for the previous several months.<br><br>The following diagnoses were coded into Resident #83's record by the Medical Records Director (Non-Nurse):<br><br>-muscle weakness (generalized), 04/26/2025<br><br>-difficulty in walking, not elsewhere classified, 04/26/2025<br><br>-attention and concentration deficit following cerebral infarction, 05/01/2025<br><br>-memory deficit following cerebral infarction, 05/01/2025<br><br>-cognitive social or emotional deficit following cerebral infarction, 05/01/2025<br><br>-encounter for surgical aftercare following surgery on the digestive system, 04/26/2025<br><br>-paroxysmal atrial fibrillation, 04/26/2025<br><br>-hyperlipidemia, unspecified, 04/26/2025<br><br>(continued on next page) |

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| | 295050 | A. Building<br>B. Wing | 07/01/2025 |

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| Life Care Center of Reno | 445 W. Holcomb Lane<br>Reno, NV 89511 |

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| F 0836<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -obstructive sleep apnea (adult), 04/26/2025<br><br>-anxiety disorder, unspecified, 04/26/2025<br><br>-gastrostomy status, 04/26/2025<br><br>-depression, unspecified, 04/26/2025<br><br>-essential (primary) hypertension, 04/26/2025<br><br>-acute sialadenitis, 04/26/2025<br><br>-history of falling, 04/26/2025<br><br>-unspecified mood (affective) disorder, 06/25/2025<br><br>The Medical Records Director (Non-Nurse)'s personnel record lacked documented evidence fingerprinting and a background check clearance had been completed.<br><br>On 06/25/2025 at 1:24 PM, the Administrator confirmed the Medical Records Director (Non-Nurse) had been accessing resident records without a NABS clearance. The Administrator verbalized not having been aware of the State requirement of skilled nursing employee background checks.<br><br>The Medical Records Director (Non-Nurse)'s job description, signed by the employee on 03/29/2023, documented the employee would perform procedures in accordance with applicable laws and regulations.<br><br>The facility policy titled, Abuse-Screening of Employees and Residents, with a review date of 05/06/2025, documented the procedure for screening of employees included a background check and would apply to all employees, including staff who provide services on behalf of the facility. |

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| F 0838<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.<br><br>Based on document review and interview, the facility failed to ensure the Facility Assessment accurately documented the training requirements for all direct care staff. This deficient practice had the potential to have placed residents at risk due to employees not having completed identified training requirements.<br><br>Findings include:<br><br>The Facility Assessment completed 05/30/2025, identified the following topics for staff training and which staff were to be trained on a topic. The trainings lacked documentation of the frequency of the required trainings:<br><br>-Communication-effective communication for direct care staff - ALL Staff.<br><br>-Resident rights and facility responsibilities - ALL Staff.<br><br>-Abuse, neglect and exploitation - ALL Staff.<br><br>-Infection Control - ALL Staff.<br><br>-Culture change - ALL Staff.<br><br>-Identification of resident changes in condition - ALL Direct Care Staff.<br><br>-Culture competency - ALL Staff.<br><br>-Quality Assurance and Performance Improvement (QAPI) - Facility Leadership<br><br>-Compliance and Ethics - ALL Staff.<br><br>-Dementia and care of the cognitive impaired - ALL Staff.<br><br>-Behavioral Health - ALL Direct Care Staff.<br><br>-Person-centered care - ALL Direct Care Staff.<br><br>-Activities of Daily Living - ALL Direct Care Staff.<br><br>-Disaster Planning - ALL Direct Care Staff.<br><br>-Medication Administration - Registered Nurse/Licensed Practical Nurse<br><br>-Measurements - Vitals and Intake and Output - ALL Direct Care Staff.<br><br>-Resident Assessment - ALL Direct Care Staff.<br><br>(continued on next page) |

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| F 0838<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | -Caring for residents with mental and psychological disorders - ALL Staff.<br><br>-Non-pharmacological management of responsive behaviors - ALL Direct Care Staff.<br><br>-Caring for residents with trauma/post-traumatic stress disorder - ALL Direct Care Staff.<br><br>-Caring for culturally diverse populations - ALL Direct Care Staff.<br><br>On 06/30/2025 at 1:36 PM, the Administrator confirmed the Facility Assessment with a completion date of 05/30/2025, was the current Facility Assessment.<br><br>On 06/30/2025 at 1:41 PM, the Administrator verbalized only Facility Leadership was required to complete the QAPI training as those were the individuals attending the QAPI meetings. The Administrator verbalized not having been aware of the requirement for all staff to complete QAPI training.<br><br>On 06/30/2025 at 1:52 PM, the Administrator verbalized all staff were receiving the required trainings, and confirmed the Facility Assessment did not document how often staff needed to be trained but should have.<br><br>The facility policy titled, Facility Assessment, with a reviewed date of 05/06/2025, documented the assessment must be updated with training requirements to include the processes and services to meet the needs of residents and of regulatory requirements. |

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| F 0844<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Follow rules about disclosure of ownership requirements and tell the state agency about changes in ownership and/or administrative personnel.<br><br>Based on interview and document review, the facility failed to ensure written notification was provided to the State Agency (SA) when the facility had a change in Director of Nursing (DON). This deficient practice had the potential to result in lack of oversight to ensure the facility employed a qualified DON.<br><br>Findings include:<br><br>On 06/22/2025, the facility provided a list of staff currently employed by the facility. The list included the DON and documented a hire date of 10/07/2024.<br><br>On 07/01/2025 at 9:13 AM, the Administrator denied the facility provided written notice to the SA when the facility last had a change in DON and explained the Administrator was unaware of the requirement to provide the written notice.<br><br>On 07/01/2025 at approximately 10:00 AM, the Administrator provided a copy of a typed letter. The letter was dated 07/01/2025 and was signed by the Administrator. The letter documented the letter was formally notifying the SA of a change in DON at the facility. The start date for DON was 10/07/2024.<br><br>The facility policy titled Changes in Executive Director and/or Director of Nursing, reviewed 05/06/2025, documented the facility was to provide written notices to the SA responsible for licensing the facility if there was a change in Executive Director and/or DON. Notice was to be provided in advance of the change, if possible, but no later than at the time of the change. The notice was to include the identity of each new individual and the date the change would take effect. |

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a plan that describes the process for conducting QAPI and QAA activities.<br><br>Based on interview and document review, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to ensure corrective action was implemented to address identified problems related to the lack of screening and education for influenza and pneumococcal vaccinations. This deficient practice had the potential to result in the exposure of all residents, staff and visitors to harmful infectious agents.<br><br>Findings include:<br><br>On 07/01/2025 at 1:47 PM, during the QAPI review with the Administrator, the Administrator verbalized the facility had identified a concern related to the lack of screening and education for influenza and pneumococcal vaccinations. The Administrator confirmed no corrective action had been put in place related to the screening and education provided for influenza and pneumococcal vaccinations.<br><br>The facility policy titled Area of Focus: QAA and QAPI Program, reviewed 11/20/2024, documented the Quality Assessment and Assurance (QAA) committee responsibilities included identifying and responding to quality deficiencies throughout the facility.<br><br>Cross reference with F883. |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>Based on observation, clinical record review, document review, and interview, the facility's Quality Assurance and Performance Improvement (QAPI)/Quality Assessment and Assurance (QAA) Committee failed to identify, develop and implement plans of action for systemic issues related to resident room changes and the facility bowel and bladder program.<br><br>Findings include:<br><br>Room Changes<br><br>On 07/01/2025 at 1:47 PM, the Administrator verbalized QAPI had identified and developed a plan for resident room changes. The Administrator verbalized the QAPI Committee began working on resident notifications of room changes in May 2025, and was still be monitored. The Administrator confirmed the corrective action should have been revised when identification of the notification sheets were not completed with room change reasons.<br><br>Bowel and Bladder Program<br><br>On 07/01/2025 at 1:47 PM, the Administrator confirmed the QAPI Committee had identified and developed a plan for the facilities bowel and bladder program, ensuring staff were rounding on residents every two hours. The Administrator verbalized this was an ongoing Performance Improvement Project, and the QAPI committee agreed the bowel and bladder program only required to include two-hour resident and bed checks.<br><br>The facility's Quality Assurance Performance Improvement (QAPI) Plan revised January 2025, documented the facility was committed to being the premier provider of long term health care in America. The facility programs, services and facilities must be designed and operated with superior quality to satisfy the needs of the residents.<br><br>Cross reference with F559. |

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| F 0868<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have the Quality Assessment and Assurance group have the required members and meet at least quarterly<br><br>Based on document review and interview the facility failed to maintain the required Quality Assurance and Performance Improvement (QAPI)/Quality Assessment and Assurance (QAA) committee members to include the Director of Nursing and the Medical Director.<br><br>Findings include:<br><br>The facility provided a list of QAPI Committee members. The list documented the QAPI committee was comprised of the Chief Executive Officer, the Chief Nursing Officer, the Medical Director or designee, the Infection Preventionist, and two other facility staff.<br><br>On 07/01/2025 at 1:47 PM, the Administrator verbalized the QAPI committee required at a minimum the Administrator, the Director of Nursing, Medical Director or designee, the Infection Preventionist and two other staff members.<br><br>The Administrator provided the QAPI sign in sheets for the following dates, the following noted QAPI members were not on the QAPI meeting sign-in sheet and were not in attendance:<br><br>July 23, 2024 - Director of Nursing (DON)<br><br>August 29, 2024 - DON<br><br>September 27, 2024 - DON<br><br>December 30, 2024 - DON<br><br>January 2025 - DON, Medical Director (MD)<br><br>February 27, 2025 - MD<br><br>March 24, 2025 - MD<br><br>April 30, 2025 - MD<br><br>On 07/01/2025 at 1:55 PM, the Administrator confirmed the aforementioned members of QAPI had not been in attendance at the identified meeting dates.<br><br>The facility policy titled Area of Focus: QAA and QAPI Program, reviewed 11/20/2024, documented the facility must maintain a quality assessment and assurance committee consisting at a minimum of the director f nursing services, the Medical director or designee, at least three other members of the facility's staff, at least one of who must be the Administrator, and the infection preventionist. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, document review, and interview, the facility failed to adhere to proper infection control protocols by allowing a resident's catheter tubing to drag on the floor while the resident was seated in a wheelchair for 1 of 24 sampled residents (Resident #69).<br><br>This deficient practice had the potential to result in contamination of the catheter tubing, urinary tract infections and increasing the risk of other complications for the resident.<br><br>Findings include:<br><br>Resident #69<br><br>Resident #69 was admitted to the facility on [DATE], with diagnoses including retention of urine, unspecified, benign prostatic hyperplasia without lower urinary tract symptoms, and chronic combined systolic (congestive) and diastolic (congestive) heart failure.<br><br>A physician's order dated 06/09/2025, documented indwelling catheter to straight drainage. Size: 16 French Bulb: 10 milliliter (ml). Change for clogging or dislodgement as needed for benign prostatic hyperplasia for infection, obstruction or when the closed system is compromised.<br><br>On 06/23/2025 at 8:16 AM, Resident #69 was seated in a wheelchair in the 400 hallway. Below the chair of the wheelchair, the resident's urinary catheter bag was on the ground.<br><br>On 06/23/2025 at 8:20 AM, a Licensed Practical Nurse (LPN) verbalized urinary catheter bags were not to be on the ground because of infection control reasons. The LPN explained Resident #69 currently had a bladder infection and was being treated for the bladder infection with antibiotics. As a result, infection control procedures needed to be followed to ensure bacteria did not enter the urinary catheter bag, affecting the resident with a negative outcome.<br><br>On 06/25/2025 at 8:48 AM, the Director of Nursing (DON) verbalized catheter bags were to be off of the ground at all times for infection control purposes, such as, contamination and bacteria getting into the Foley, which could cause a Urinary Tract Infection (UTI).<br><br>The DON explained the resident came to the facility with a UTI and staff were required to hang the bag off of the ground at all times, as well as, checking for placement of the bag whether the resident was in or out of bed.<br><br>The facility policy titled Catheter Care, Urinary, last revised September 2014, documented use standard infection control precautions when handling or manipulating the drainage bag. Staff were to be sure the catheter tubing and drainage bag were kept off of the floor.<br><br>The facility policy titled Indwelling urinary catheter (Foley) care and management, undated, documented do not place the drainage bag on the floor to reduce the risk of contamination and a subsequent catheter associated urinary tract infection (CAUTI). |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, interview, and document review, the facility failed to ensure that 38 of 38 residents (Resident #46, #270, #72, #83, #55, #421, #75, #277, #85, #54, #68, #61, #10, #222, #69, #4, #78, #20, #171, #1, #32, #38, #223, #48, #16, #35, #27, #19, #74, #96, #93, #34, #7, #2, #15, #9, #25, and #91) reviewed for immunizations were appropriately screened for eligibility to receive influenza (flu) and pneumococcal vaccines (PNA). The facility did not consistently determine the correct vaccine for each resident, provide education regarding the specific vaccines for which residents were eligible, or ensure that informed consent forms were properly completed and signed. Additionally, residents who were eligible to receive influenza or pneumococcal vaccines did not consistently receive the vaccinations as required. This deficient practice resulted in substandard quality of care and placed residents at increased risk for vaccine-preventable illnesses.<br><br>Findings include:<br><br>Resident #46<br><br>Resident #46 was admitted to the facility on [DATE], with diagnoses including chronic systolic (congestive) heart failure, and dependence on supplemental oxygen.<br><br>Resident #270<br><br>Resident #270 was admitted to the facility on [DATE], with diagnoses including chronic systolic (congestive) heart failure, and chronic kidney disease, stage III.<br><br>Resident #72<br><br>Resident #72 was admitted to the facility on [DATE], with diagnoses including diabetes mellitus, type II, with diabetic neuropathy, long term (current) use of insulin.<br><br>Resident #83<br><br>Resident #83 was admitted to the facility on [DATE], with diagnoses including hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left non-dominant side, type II diabetes mellitus without complications, paroxysmal atrial fibrillation, and essential (primary) hypertension.<br><br>Resident #55<br><br>Resident #55 was admitted to the facility on [DATE], with diagnoses including acute respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), unspecified asthma, uncomplicated, and severe sepsis with septic shock.<br><br>Resident #421<br><br>(continued on next page) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Resident #421 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including pneumonia, unspecified organism, malignant neoplasm of esophagus, unspecified, protein-calorie malnutrition, and adult failure to thrive.<br><br>Resident #75<br><br>Resident #75 was admitted to the facility on [DATE], with diagnoses including type II diabetes mellitus with other specified complication, and unspecified protein-calorie malnutrition.<br><br>Resident #277<br><br>Resident #277 was admitted to the facility on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, type II diabetes mellitus without complications, and essential (primary) hypertension.<br><br>Resident #85<br><br>Resident #85 was admitted to the facility o 04/29/2025, and readmitted on [DATE], with diagnoses including end stage renal disease, dependence on renal dialysis, acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure, peripheral vascular disease, unspecified, and type II diabetes mellitus without complications.<br><br>Resident #54<br><br>Resident #54 was admitted to the facility on [DATE], with diagnoses including type II diabetes mellitus without complications, pulmonary hypertension, unspecified, acute respiratory failure with hypoxia, and dependence on supplemental oxygen.<br><br>Resident #68<br><br>Resident #68 was admitted to the facility on [DATE], with diagnoses of malignant neoplasm of unspecified part of right bronchus or lung, and essential (primary) hypertension.<br><br>Resident #61<br><br>Resident #61 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including type I diabetes mellitus with ketoacidosis without coma, end stage renal disease, pulmonary hypertension, unspecified, anemia in chronic kidney disease, heart failure, unspecified, cardiomegaly, dependence on supplemental oxygen, and adult failure to thrive.<br><br>Resident #10<br><br>Resident #10 was admitted to the facility on [DATE], with diagnoses including heart failure, unspecified, adult failure to thrive, and essential (primary) hypertension.<br><br>Resident #222<br><br>(continued on next page) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Resident #222 was admitted to the facility on [DATE], with diagnoses including unspecified asthma, uncomplicated, type II diabetes mellitus without complications, unspecified severe protein-calorie malnutrition, and essential (primary) hypertension.<br><br>Resident #69<br><br>Resident #69 was admitted to the facility on [DATE], with diagnoses including chronic combined systolic (congestive) and diastolic (congestive) heart failure, and essential (primary) hypertension.<br><br>Resident #4<br><br>Resident #4 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including paraplegia, unspecified, and direct infection of right hip in infectious and parasitic diseases.<br><br>Resident #78<br><br>Resident #78 was admitted to the facility on [DATE], with diagnoses including COPD with (acute) exacerbation, emphysema, unspecified, pneumonia due to other gram-negative bacteria, and peripheral vascular disease, unspecified.<br><br>Resident #20<br><br>Resident #20 was admitted to the facility on [DATE], with diagnoses including acute and chronic respiratory failure with hypoxia, COPD, unspecified, type II diabetes mellitus, chronic diastolic (congestive) heart failure, dependence on supplemental oxygen, and anemia in chronic kidney disease.<br><br>Resident #171<br><br>Resident #171 was admitted to the facility on [DATE], with diagnoses including COPD unspecified, memory deficit following non-traumatic intracerebral hemorrhage, and seizures.<br><br>Resident #1<br><br>Resident #1 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including acute and chronic respiratory failure with hypoxia, acute and chronic respiratory failure with hypercapnia, acute on chronic systolic (congestive) heart failure, pulmonary hypertension, unspecified, essential (primary) hypertension, and dependence on supplemental oxygen.<br><br>Resident #32<br><br>Resident #32 was admitted to the facility on [DATE], with diagnoses including after care following joint replacement surgery, and essential (primary) hypertension.<br><br>Resident #38<br><br>(continued on next page) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Resident #38 was admitted to the facility on [DATE], with diagnoses including COPD, unspecified, acute respiratory failure with hypoxia, unspecified protein-calorie malnutrition, chronic diastolic (congestive) heart failure, peripheral vascular disease, and malignant neoplasm of pharynx, unspecified.<br><br>Resident #223<br><br>Resident #223 was admitted to the facility on [DATE], with diagnoses including acute on chronic diastolic (congestive) heart failure, other pulmonary embolism with acute cor pulmonale, and other pancytopenia.<br><br>Resident #48<br><br>Resident #48 was admitted to the facility on [DATE], with diagnoses including acute transverse myelitis in demyelinating disease of central nervous system, and essential (primary) hypertension.<br><br>Resident #16<br><br>Resident #16 was admitted to the facility on [DATE], with diagnoses including chronic respiratory failure with hypoxia, chronic respiratory failure with hypercapnia, chronic kidney disease, stage III, unspecified, and essential (primary) hypertension.<br><br>Resident #35<br><br>Resident #35 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including other sequelae of cerebral infarction, type II diabetes mellitus with hyperglycemia, chronic kidney disease stage III, unspecified, and essential (primary) hypertension.<br><br>Resident #27<br><br>Resident #27 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including metabolic encephalopathy, malignant neoplasm of brain, unspecified, paraplegia, incomplete, and acute respiratory failure with hypoxia.<br><br>Resident #19<br><br>Resident #19 was admitted to the facility on [DATE], with diagnoses including other seizures, occlusion and stenosis of right carotid artery, primary osteoarthritis, unspecified hand, and essential (primary) hypertension.<br><br>Resident #74<br><br>Resident #74 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including type II diabetes mellitus without complications, essential (primary) hypertension, and cognitive social or emotional deficit following cerebral infarction.<br><br>Resident #96<br><br>(continued on next page) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Resident #96 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unspecified atrial fibrillation, interstitial pulmonary disease, unspecified, primary pulmonary hypertension, right heart failure, unspecified, acute and chronic respiratory failure with hypoxia, acute and chronic respiratory failure with hypercapnia, and dependence on supplemental oxygen.<br><br>Resident #93<br><br>Resident #93 was admitted to the facility on [DATE], with diagnoses including end stage renal disease, unspecified asthma, uncomplicated, type II diabetes mellitus without complications, and dependence on renal dialysis.<br><br>Resident #34<br><br>Resident #34 was admitted to the facility on [DATE], with diagnoses including cerebral infarction due to embolism of left meddle cerebral artery, and essential (primary) hypertension.<br><br>Resident #7<br><br>Resident #7 was admitted to the facility on [DATE], multiple sclerosis, and unspecified atrial fibrillation.<br><br>Resident #2<br><br>Resident #2 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including type II diabetes mellitus, long term (current) use of insulin, end stage renal disease, and dependence on dialysis.<br><br>Resident #15<br><br>Resident #15 was admitted to the facility on [DATE], with diagnoses including malignant neoplasm of right renal pelvis, traumatic hemorrhage of cerebrum, unspecified, with loss of consciousness status unknown, subsequent encounter, pneumonia, unspecified organism, and acquired absence of kidney.<br><br>Resident #9<br><br>Resident #9 was admitted to the facility on [DATE], with diagnoses including pneumonia due to other gram-negative bacteria, acute respiratory failure with hypoxia, acute kidney failure, unspecified, and myocardial infarction type II.<br><br>Resident #25<br><br>Resident #25 was admitted to the facility on [DATE], with diagnoses including chronic respiratory failure with hypoxia, pneumonia, unspecified organism, unspecified atrial fibrillation, acute kidney failure, unspecified, and dependence on supplemental oxygen.<br><br>Resident #91<br><br>(continued on next page) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Resident #91 was admitted to the facility on [DATE], with diagnoses including neutropenia, unspecified, acute kidney failure, unspecified, and bacteremia.<br><br>Influenza Vaccine<br><br>A form titled Informed Consent for Influenza Vaccine: Inactivated/recombinant (Influenza Consent Form) last revised 09/2022, documented the following:<br><br>-The facility must provide the most current edition of the Centers for Disease Control and Prevention (CDC) Vaccine Information Statement (VIS) for the vaccine to be administered.<br><br>-The VIS form explained the risk and benefits of receiving the vaccine.<br><br>-Residents/resident representatives should read the VIS before consenting to receiving the vaccine.<br><br>-A section to enter the vaccine the resident was being offered and the date.<br><br>-A section to document the date of the VIS form and the date the form was actually provided.<br><br>-A check box indicating the resident/resident representative consented to having the vaccine administered and included acknowledgment education regarding the indicated vaccine had been provided and the resident/resident representative understood the risk and benefits of receiving the vaccine.<br><br>-A check box indicating the resident did not consent to receiving the vaccine and included an acknowledgement the resident/resident representative, received education regarding the risk and benefits of the above vaccine.<br><br>-The Influenza consent form did not including resident screening questions for eligibility including fever or other signs or symptoms of illness, allergies to medications, food, and/or vaccine components, a history of serious reaction to vaccines, health history, medications, history of administration of blood products, vaccination history, history of dizziness or fainting related to the administration of a vaccine, and how the resident felt about receiving the vaccine.<br><br>An Influenza Consent Form signed by (Resident #270, #72, #83, #55, #75, #277, #85, #222, #4, #20, #1, #32, #223, #16, #27, #74, #93, #2, #9, and #25, or the residents' representative) documented the residents declined immunization with a flu vaccine. The Influenza Consent Forms did not include documentation of the type of flu vaccine offered and lacked documented evidence the residents were screened for eligibility to receive a flu vaccine, which flu vaccine was offered, and if education regarding the flu vaccine including the VIS form was provided.<br><br>Resident #46, #61, #10, #35, #19, and #15<br><br>(continued on next page) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Resident #46, #61, #10, #35, #19, and #15, and/or the residents' representative, signed and/or verbally consented to the resident receiving a flu vaccine. The consent was documented on a blank/incomplete Influenza Consent Form and dated 10/02/2024. The Influenza Consent Form documented the residents had not been screened for eligibility to receive a flu vaccine, which flu vaccine to administer, and safety related to administration of the vaccine including history of allergies or reactions to a vaccine or contraindications related to the residents' health history, and if education related to the flu vaccine, including the VIS form, was provided.<br><br>The residents' Immunization Reports documented the residents were/were not administered a flu vaccine as follows:<br><br>-Resident #46, #61, #10, #19 and #15's Immunization Report documented the residents were administered Flucelvax influenza vaccine on 10/06/2024.<br><br>-Resident #35's Immunization Report lacked documented evidence the resident was administered an influenza vaccine during the 2024/2025 flu season.<br><br>Resident #96, #69, #48, 54, #171, and #68<br><br>A form titled Universal Vaccine Informed Consent/Declination Form, (Universal Consent), with an issue date of 07/25/2023. The Universal Consent form included a section to document the name of the vaccine being consented or declined, an acknowledgement of having read/received the VIS form for the vaccine named on the form, consent and declination boxes, and a vaccine administration grid. The Universal Consent form also contained a screening tool including questions regarding current health status, history of allergic reactions including foods, medications, and latex, post vaccination reactions, history of Guillain Barre Syndrome, and immunocompromising medications and diagnoses. The reason for declination was required to be documented on the form. If the vaccine was received elsewhere, the date and location were required to be documented. The Universal Consent form also included a grid for documenting the administration of a vaccine.<br><br>Resident #96, #69, #54, #171, and #68's clinical record did not include an influenza consent form. Resident #96, #69, and #54's clinical record included a Universal Form completed as follows:<br><br>-Resident #96's Universal Consent form, signed and dated 05/28/2025, the form was marked I do not give consent to being vaccinated with this vaccine because, however did not include the name or type of vaccine and did not include any additional documentation.<br><br>-Resident #69's Universal Consent form, signed and undated, was marked I do not give consent to being vaccinated with this vaccine because but did not include the name or type of vaccine and did not include any additional documentation. A signature was entered into the line provided to document the reason the vaccine was being declined. The form did not include any additional documentation.<br><br>-Resident #48's Universal Consent form, signed and dated 06/08/2025, was marked I do not give consent to being vaccinated with this vaccine because. The screening section was completed by drawing a line through the boxes labeled for each question on the form. The Universal Consent form did not include any additional documentation, including the name and type of vaccine.<br><br>(continued on next page) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -Resident #54's Universal Consent form, signed and dated 06/07/2025, was marked I do not give consent to being vaccinated with this vaccine because, but did not include the name or type of vaccine. The screening section was completed by writing an X in the top box labeled No and a line was drawn through each of the remaining screening boxes. The Universal Consent form did not include any additional documentation, including the name and type of vaccine.<br><br>-Resident #171's Universal Consent form, signed and dated 06/12/2025, was marked I give consent but did not include any additional information including the name and/or type of vaccine.<br><br>-Resident #68's Universal Consent form, signed and dated 05/28/2025, was marked I give consent and the screening section was completed by placing a mark in the no box for each question. The form did not include any additional information including the name and/or type of vaccine.<br><br>Resident #38, #421, #7, #91, and #34<br><br>Resident #38, #421, #7, #91, and #34's clinical record did not include an Influenza Consent form or a Universal Consent form, and did not include any additional documentation related to screening the residents for eligibility to receive a flu vaccine, the type of flu vaccine the resident was eligible to receive, if the resident consented or declined the vaccine and if education regarding the vaccine was provided to the residents. The Residents' immunization reports documented the following:<br><br>-Resident #38 Immunization Record documented the resident was last administered a flu vaccine on 09/06/2023.<br><br>-Resident #421 Immunization Record documented the resident was last administered a flu vaccine on 08/29/2024. The vaccination was documented as historical but did not document where the vaccine was received.<br><br>-Resident #7 was last administered a flu vaccine on 10/10/2024. The vaccination was documented as historical but did not document where the vaccine was received.<br><br>-Resident #91's Immunization Record documented the resident was not eligible to receive a flu vaccine and did not document the reason why.<br><br>-Resident #34's Immunization Record documented the resident was last administered a flu vaccine on 03/02/2023. The vaccine was administered by the facility.<br><br>Resident #38<br><br>Resident #38's Influenza Consent form documented a verbal consent was obtained on 11/19/2024. The form lacked any additional documentation, including if the resident's responsible party did or did not consent to the resident receiving a flu vaccine. The form did not document the resident was screened for eligibility, the type of flu vaccine and the education offered for the vaccine, including a VIS.<br><br>(continued on next page) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | The facility policy titled Influenza Vaccine Policy for Resident revised on 01/28/2025, documented consents and declinations were documented annually and entered into the residents' medical record. The facility re-addressed refusals with residents and/or the residents' representative each year to ensure the resident or the resident's representative had not changed their decision. These conversations were entered into the medical record.<br><br>Education was provided the resident and/or the resident representative by providing the VIS form for the vaccine to be administered. The resident was assessed/screened for possible contraindications and if noted the physician was notified for further instructions. Education, assessment findings, administration, refusal or did not receive due to medical contraindications, and monitoring were documented in the resident's medical record.<br><br>Pneumococcal Vaccine<br><br>Resident #421 and #91<br><br>Resident #421 and Resident #91's clinical record did not include documented evidence the residents were screened for eligibility to receive a PNA vaccine, education regarding PNA vaccines was provided, and consent was obtained to receive a PNA vaccine, or the vaccine was declined.<br><br>Resident #421's Immunization Report did not include documentation of a PNA vaccine being administered or declined.<br><br>Resident #91's Immunization Report documented the resident had refused immunization with a pneumococcal vaccine; the entry was undated.<br><br>Resident #4, #1, #19, and #15<br><br>Resident #4, #1, #19, and #15's clinical records lacked documented evidence the residents were screened for eligibility to receive a PNA vaccine, provided education regarding the PNA vaccine the resident was eligible to receive, and either consented or did not consent to vaccination with a pneumococcal vaccine when CDC guidance was updated, and new vaccines became available. The residents were last screened for PNA vaccines as follows:<br><br>-Resident #4 and #15's clinical record included a form titled Informed Consent for Pneumococcal Vaccine PCV13, (Pneumococcal Conjugate) and PPSV23 (Pneumococcal Polysaccharide) signed and dated 10/21/2021, documented Resident #4 declined to receive vaccination with a pneumococcal vaccine.<br><br>-Resident #4's Immunization Report documented the resident was administered a PNA vaccine on 12/23/2015. The Immunization Report documented the resident had refused a PNA vaccine twice, but did not document a date the vaccines were declined.<br><br>-Resident #15's Immunization Report documented the resident was administered a PNA vaccine on 12/14/2023. The Immunization Report documented the resident had refused a PNA vaccine twice, but did not document a date the vaccines were declined.<br><br>(continued on next page) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -Resident #1's clinical record included a form titled Informed Consent for Pneumococcal Vaccine. The form was undated, but documented parts of the form were excerpted from CDC VIS forms dated 11/05/2015 (PCV-13 vaccine) and 04/24/2015 (PPSV vaccine).<br><br>-Resident #1's Immunization Record lacked documentation the resident had ever received immunization with a pneumococcal vaccine.<br><br>-Resident #19's clinical record included a form titled Informed Consent for Pneumococcal Polysaccharide Vaccine (for PCV13 consent see CP1818). The form was undated, but documented parts of the form were excerpted from a CDC VIS form for Pneumococcal Polysaccharide Vaccine dated 01/06/2009. The form was signed and dated 02/26/2023, and documented a PNA vaccine was declined.<br><br>-Resident #19's Immunization Record documented the resident had refused a pna vaccine twice, the refusals were not dated. The Immunization Record documented the resident was administered a dose of Pneumovax (PPSV23) on 09/06/2023.<br><br>The facility was not able to provide updated documentation of screening, education, and/or a signed consent for vaccination with, or declination of a PNA vaccine per the most recent CDC guidance for Resident #4, #1, #19, and #15.<br><br>Resident #46, #10, #78, #72, #16, #27, and #34<br><br>A form titled Informed Consent for Pneumococcal Vaccine PCV-15 or PCV-20 (Pneumococcal Conjugate) and PPSV23 (Pneumococcal Polysaccharide) (PNA Consent 1) dated 04/2022, included information regarding the three PNA vaccine recommended by the CDC as of 04/2022.<br><br>The PNA Consent 1 form documented individuals over [AGE] years of age who had not previously received vaccination with PCV-15 or PCV-20 or had an unknown vaccination should be administered a dose of either PCV-15 or PCV-20. If PCV-15 was used, it should be followed with a dose of PPSV23 at least one year later.<br><br>The PNA Consent 1 form documented the most current edition of the CDC's VIS must be provided to the resident and/or the resident's representative for the vaccine the individual was determined to be eligible to receive. The form encouraged the individual receiving the vaccine to read the VIS prior to consenting.<br><br>The PNA Consent 1 form included a section for documenting which vaccine (PCV-15, PCV-20 and PPSV-23) was being offered and the date. The PNA consent form included a section to document which of the VIS forms was provided, the date of the VIS form, and the date the education was provided.<br><br>The PNA Consent 1 form included a section to consent and a section to decline to consent. Both sections, I consent or I do not consent, documented the consenting party (resident and/or resident representative) received information about the risk and benefits of the vaccine being offered.<br><br>(continued on next page) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Resident #46, #10, #78, #16, #27, and #34's PNA Consent 1 form included the resident and/or the resident representatives' signature, and I do not consent was selected for each of the residents. The PNA Consent 1 forms signed by the Resident #46, #10, #78, #72, #16, #27, and #34, and/or the residents representative, did not include screening for eligibility. The sections of the PNA 1 Consent form indicating the PNA vaccine offered and the date the vaccine was offered was not completed, and the section documenting which VIS form was provided, the date of the VIS form, and the date the VIS form (education) was provided to the resident and/or the residents' representative was left blank.<br><br>The Immunization Records for Resident #46, #10, #78, #16, #27, and #34, documented PNA vaccines were received or refused as follows:<br><br>-Resident #46, one dose of PPSV23 was given on 11/01/2021 (historical). Not eligible was documented twice and was undated.<br><br>-Resident #10, documented PPSV23 was administered on 09/06/2023. A PNA vaccine was documented as refused one time.<br><br>-Resident #78, lacked documentation related to a PNA vaccine.<br><br>-Resident #16, a PNA vaccine was documented as refused one time, undated.<br><br>-Resident #27, a PNA vaccine was documented as refused one time, undated.<br><br>-Resident #34, one dose of PPSV23 was given on 10/30/2021. Not eligible was documented twice and was undated.<br><br>Resident #72's PNA Consent 1 form included the resident's signature and was dated 09/11/2024. The form documented the resident consented to receive a PNA vaccine. The PNA Consent 1 forms signed by Resident #72 did not include screening for eligibility. The sections of the PNA 1 Consent form indicating the PNA vaccine offered and the date the vaccine was offered was not completed, and the section documenting which VIS form was provided, the date of the VIS form, and the date the VIS form (education) was provided to the resident was left blank.<br><br>Resident #72's Immunization Record lacked documented evidence the resident was administered a PNA vaccine at any time.<br><br>Per the CDC's PneumoRecs VaxAdvisor Residents #46, #10, #78, #72, #16, #27, and #34 were eligible to receive a PNA vaccine based on the residents age and/or qualifying comorbidities, such as end stage renal failure and dependence on dialysis.<br><br>The facility was not able to provide updated documentation of screening, education, and/or a signed consent for vaccination with, or declination of a PNA vaccine per the most recent CDC guidance for Resident #46, #10, #78, #72, #16, #27, and #34.<br><br>Resident #55, #75, #20, #61, and #35<br><br>(continued on next page) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | A form titled Informed Consent for Pneumococcal Vaccine PCV-15, PCV-20, or PCV-21 (Pneumococcal Conjugate) and PPSV23 (Pneumococcal Polysaccharide) (PNA Consent 2) form dated 09/2024, included information regarding PNA vaccination recommendations for vaccination.<br><br>The PNA Consent 2 form documented individuals over [AGE] years of age who had not previously received a Pneumococcal Conjugate vaccine, or had an unknown vaccination history, should be administered a dose of either PCV-15, PCV-20, or PCV21. If PCV-15 was used, it should be followed with a dose of PPSV23 at least one year later.<br><br>The form documented the most current edition of the CDC's VIS must be provided for the vaccine the individual was determined to be eligible to receive. The form encouraged the individual receiving the vaccine to read the VIS prior to consenting.<br><br>The PNA Consent 2 form included a section for documenting which vaccine (PCV-15, PCV-20, PCV-21 and PPSV-23) was being offered and the date. The PNA consent form included a section to document which of the VIS forms was provided, the date on the VIS form, and the date the education was provided.<br><br>The PNA Consent 2 form included a section to consent and a section to decline to consent. Both sections, I consent or I do not consent, documented the consenting party (resident and/or resident representative) received information about the risk and benefits of the vaccine being offered.<br><br>Resident #55, #75, #20, #61, and #35 PNA Consent 2 form included the resident and/or the resident representatives' signature, and I do not consent was selected for each of the residents. The PNA Consent 2 forms signed by Resident #55, #75, #20, #61, and #35, and/or the residents' representative, did not include screening for eligibility. The sections of the PNA Consent 2 form indicating the PNA vaccine offered and the date the vaccine was offered was not completed, and the section documenting which VIS form was provided, the date of the VIS form, and the date the VIS form (education) was provided to the resident and/or the residents' representative was left blank.<br><br>The Immunization Records for Resident #55, #75, #20, #61, and #35 documented PNA vaccines were received or refused as follows:<br><br>-Resident #55, Pneumovax was refused one time, undated.<br><br>-Resident #75, a dose of PPSV23 was refused one time, undated. One dose of PCV20 was administered on 10/07/2024 (historical).<br><br>-Resident #20, a dose of PPSV23 was refused two times, undated. One dose of PCV20 was administered on 02/15/2023 (historical).<br><br>-Resident #61, no documentation a PNA vaccine was refused or administered.<br><br>-Resident #35, a dose of PPSV23 was refused one time.<br><br>Per the CDC's PneumoRecs VaxAdvisor Per the CDC's PneumoRecs VaxAdvisor Residents #55, #75, #20, #61, and #35 were eligible to receive a PNA vaccine based on the residents age and/or qualifying comorbidities, such as end stage renal failure and dependence on dialysis.<br><br>(continued on next page) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | The facility was not able to provide updated documentation of screening, education, and/or a signed consent for vaccination with, or declination of a PNA vaccine per the most recent CDC guidance for Resident #55, #75, #20, #61, and #35<br><br>Resident #270, #83, #277, #85, #54, #69, #222, #69, #171, #32, #38, #48, #223, #74, #96, #93, #7, #2, #9, and #25.<br><br>A form titled Informed Consent for Pneumococcal Vaccine PCV-15, PCV-20, or PCV-21 (Pneumococcal Conjugate) and PPSV23 (Pneumococcal Polysaccharide) (PNA Consent 3) form dated 01/2025, included information regarding PNA vaccine recommendations. The PNA Consent 3 form contained the most recent CDC guidance for immunization with flu vaccines.<br><br>The PNA Consent 3 form documented individuals over [AGE] years of age and those at increased risk for pneumococcal disease, who had not previously received a Pneumococcal Conjugate vaccine, or had an unknown vaccination history, should be administered a dose of either PCV-15, PCV-20, or PCV21. If PCV-15 was used, it should be followed with a dose of PPSV23 at least one year later.<br><br>The PNA Consent 3 form documented the most current edition of the CDC's VIS must be provided for the vaccine the individual was determined to be eligible to receive. The form encouraged the individual receiving the vaccine to read the VIS prior to consenting.<br><br>The PNA Consent 3 form included a section for documenting which vaccine (PCV-15, PCV-20, PCV-21 and PPSV-23) was being offered and the date. The PNA consent form included a section to doc |