STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295077	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alta Skilled Nursing and Rehabilitation Center	555 Hammill Lane 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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34524 Based on clinical record review, interview, and document review, the facility failed to ensure a resident's dignity was maintained for 1 of 18 sampled residents (Resident #9). Resident #9 Resident #9 was admitted to the facility on [DATE] with a diagnosis including hydrocephalus and difficulty walking. A Facility Reported Incident (FRI) documented on 02/23/2024, the allegation a Physical Therapist (PT) was witnessed verbally berating a resident at the nurse's station. A Communication Note dated 02/23/2024, documented the writer spoke with Resident #9 regarding the interaction with the PT. Resident #9 expressed the resident was okay and the interaction was just a misunderstanding. The writer expressed to the resident the PT was just trying to make sure the resident was safe since the resident was not cleared to ambulate on their own. The resident agreed and expressed the PT's demeanor needed to be gentler. Resident #9's Comprehensive Care Plan initiated 02/23/2024, documented the resident was at risk for loss of dignity related to stern instructions from a staff member and included: -resident's dignity would be maintained through the next review as evidenced by no crying noted when being educated for not being compliant. - notify physician and next of kin whenever resident felt like instructions were given harshly. -resident would be assessed for signs of emotional distress like crying and withdrawal. -resident would be provided with a reason when providing instructions. -The resident would be encouraged to verbalize feelings and concerns. -resident would be provided with instruction like do not ambulate by self. -trauma screen would be conducted as needed. (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 04/03/2024 at 12:05 PM, during a telephone interview, Resident #9 verbalized the resident was walking through the facility when a PT confronted the resident and yelled at the resident for walking around. The resident recalled the resident broke down into tears. The resident left the area and went back to their room. The resident stated the resident felt disrespected. Other residents and staff were present during the incident and the resident was very embarrassed to have the confrontation happen in front of other people. On 04/03/2024 at 12:26 PM, a Registered Nurse (RN) verbalized Resident #9 was walking with a walker in the library to pick out a book. The PT saw Resident #9 and began yelling out what are you doing?! Get back to your room right now! The PT told the resident Let's go and forcefully and militantly walked the resident back to their room. The resident did not get to pick out a book. The RN recalled Resident #9 was upset and crying and informed the RN the resident would rather leave against medical advice than work with the PT again. The RN notified the Administrator and Director of Nursing (DON). On 04/05/2024 at 10:43 AM, the Administrator verbalized the DON was informed of the incident by the RN who witnessed the incident. Resident #9 was interviewed along with the RN who witnessed the incident. The Administrator recalled the investigation showed Resident #9 was ambulating by themselves toward the library. The PT saw the resident and intervened. The PT told the Administrator the PT witnessed the resident's unsafe attempts to get a book off the shelf and the PT stopped the resident. The PT stated the PT was rough around the edges when instructing the resident to go back to their room. The PT was suspended, and statements were taken from all parties involved. The Social Worker interviewed Resident #9 and completed a Trauma Screening. Education was provided to the PT on 02/28/2024. The topic of the in-service education was Proper Resident Communication and De-escalation strategies. The facility policy titled Resident [NAME] of Rights, last revised 12/06/22, documented residents had the right to be treated with respect and dignity in a manner to promote and enhance quality of life and recognizing each resident's individuality. FRI #NV00070552

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34524 Based on clinical record review, interview, and document review the facility failed to ensure 1) a resident was kept safe from verbal abuse by a staff member for 1 of 18 sampled residents (Resident #7). Findings include: Resident #7 Resident #7 was admitted to the facility on [DATE], with diagnoses including unspecified chronic bronchitis, unspecified severe protein calorie malnutrition, and depression. Resident #19 Resident #19 was admitted to the facility on [DATE], with a diagnosis of paroxysmal atrial fibrillation. A Facility Reported Incident (FRI) documented on 03/20/2024, the allegation of a staff member witnessed verbally berating a resident at the nurse's station. A Nursing Note dated 02/11/2024, documented the Director of Nursing (DON) received a telephone call from a Certified Nursing Assistant (CNA) who, along with a family member of a resident witnessed a Registered Nurse (RN) verbally berate Resident #7 at the nurse's station. The nurse was cursing and throwing medication bottles around the nurses' station. Comments were aimed at the resident, per the CNA and the family member statement. The on-call manager was notified, and the nurse was relieved, taken off the floor and sent home. Resident #7's Comprehensive Care Plan initiated 02/11/2024, documented the resident was at risk for loss of dignity related to verbal berating from staff member, and included: - Resident's dignity would be maintained through the next review. - Medical Director and family notified of the verbal altercation. - Psychosocial screen would be done on the resident to ensure no adverse effects from staff/resident verbal altercation. - Staff member suspending pending investigation. A Trauma Screening dated 02/12/2024, documented Resident #7 answered no to this question: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Sometimes things happened to people that were unusually or especially frightening, horrible, or traumatic. For example, a serious accident or fire, a physical or sexual assault or abuse, an earthquake or flood, a war, seeing someone be killed or seriously injured, having a loved one die through homicide or suicide. Have you ever experienced this kind of event? A statement from the DON dated 02/12/2024, documented the DON received a phone call from a CNA requesting the DON contact Resident #19's family member regarding the way an RN was treating a resident at the nurse's station. The DON called Resident #19's family member and the family member stated they were concerned because the RN was being very unprofessional; cursing and using terrible language that could be overheard down the hall. The family member was visiting Resident #19 when they heard the incident. The family member poked their head out of the door and looked down the hall and saw a resident sitting in a wheelchair at the nurse's station. The family member was not sure if the RN was yelling at the resident or just cursing in general and throwing items around the nurse's station. The family member asked the DON to not have the RN care for Resident #19 any longer. On 04/04/2024 at 8:29 AM, Resident #19 verbalized the RN was not nice when the RN came into to the resident's room. The resident did not recall speaking with anyone regarding the incident. On 04/04/2024 at 9:42 AM, the DON verbalized the RN was no longer an employee and was not brought back after the incident with Resident #7. The DON explained once the DON was notified of the incident, the investigation began immediately, and the RN was suspended. A Unit Manager was called in to relieve the RN and the RN was sent home. Social Services completed a trauma screening to determine if there was psychosocial harm related to the incident. The Trauma Screening asked pointed questions about how the resident felt and what happened. The DON reviewed the Trauma Screening and confirmed the Trauma Screening did not speak to the actual event. The DON explained the DON would expect the Trauma Screening to ask questions about the specific incident. On 04/04/2024 at 10:17 AM, the Social Worker (SW) verbalized when there was an incident between staff and residents, the SW would interview the resident of concern and conduct a Trauma Screen to determine if psychosocial harm occurred. The SW confirmed a Trauma Screen was completed for Resident #7 and the Trauma Screen did not indicate the resident experienced psychosocial harm. The SW confirmed the Trauma Screen asked a general question that was not specific to the incident. The SW verbalized the resident answered no to the question in the screen and there were no other questions triggered. The SW confirmed the resident was not referred to Behavioral Health Services to determine psychosocial harm because the Trauma Screening did not indicate the resident had psychosocial harm. On 04/04/2024 at 11:05 AM, during a telephone interview, a CNA verbalized the CNA was at the nurse's station speaking with another resident's family member when the RN began yelling at Resident #7 at the nurse's station regarding medication. The RN was saying you can take the whole bottle, I don't care, it's not going to kill you. The RN was yelling and slamming medication containers down. Resident #19 resided down the hall from the nurse's station. Resident #19's family member heard the yelling and came out to the hall. The family member was concerned as their minor child was in the room and could hear the cursing. The family member asked the nurse not to provide care to Resident #19 any longer. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The CNA explained the behavior was normal for the RN. The RN would call staff and residents names to their faces and behind their backs. The RN would get upset when a resident requested pain medications or exhibited behaviors. The RN would get upset and yell and curse at the residents, sometimes calling them names. The CNA verbalized residents were shocked by the way the RN spoke to them and were reluctant to ask the RN for medications. The CNA explained the CNA was speaking with a resident at the nurse's station when the RN began throwing a fit at Resident #7. The resident the CNA was speaking with was scared to walk by the RN at the nurse's station to get back to their room. On 04/04/2024 at 11:20 AM, the Human Resource Manager (HR) verbalized the RN was no longer employed by the facility as of 02/16/2024. The HR Manager explained the RN had received disciplinary action in the past for misconduct. The HR Manager confirmed the RN was terminated due to misconduct. A Disciplinary Action Form dated 06/08/2023, documented a final warning. The RN's performance was found unsatisfactory for verbal misconduct and unprofessional verbal conduct with residents and staff. A document titled Termination Details, dated 02/16/2024 documented the RN was involuntarily terminated due to misconduct unbecoming of nurse duties. On 04/04/2024 at 12:15 PM, the Corporate Social Worker (CSW) verbalized a Trauma Screening was completed for the resident after the incident and there were no indications of psychosocial harm. The resident verbalized they did not experience any trauma due to the incident. The CSW verbalized the incident was witnessed but there was no harm to the resident as the outcome. The CSW explained the nurse in question was no longer employed by the facility. On 04/04/2024 at 12:22 PM, a Licensed Practical Nurse (LPN) verbalized the RN did yell and curse often and the LPN had heard concerns from other residents about the nurse's behavior. On 04/04/2024 at 2:24 PM, Resident #19's family member verbalized over the phone the family member was visiting Resident #19 with their minor child. During the visit, the family member heard a commotion down the hall. The commotion got louder and louder and the family member heard cursing. The family walked out of Resident #19's room and into the hallway and witnessed an RN yelling at a resident in a wheelchair at the nurse's station. The family member recalled the RN was picking up medications and throwing them around the nurse's station, being very aggressive with the resident. The resident in the wheelchair did not react to the RN. The family member recalled they left the facility crying, knowing they were leaving Resident #19 in the facility with that nurse. The family member begged a CNA to watch over the resident. The family member gave a statement of the events to the DON. On 04/05/2024 at 10:20 AM, the Administrator verbalized FRI investigation documentation should include interviews with the alleged staff and residents and staff involved or affected by the incident. The Administrator explained the Administrator and the DON shared the responsibility of Abuse Coordinator. The DON was notified of the allegation and completed the initial report, interviewed staff who witnessed the incident, suspended the alleged employee, and ensured trauma screening was completed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/05/2024 at 10:21 AM, the DON verbalized the DON was notified of the allegations by the CNA that witnessed the incident. The CNA informed the DON Resident #19's family member requested to speak with the DON regarding the incident. Resident #19 was upset because they heard the RN cursing at the nurse's station and at a resident. The DON recalled Resident #7 had asked for pain medication and the RN had already given it. Resident #7 became upset with the RN. In turn, the RN became upset with Resident #7. The DON recalled the DON called the RN and informed them they were being taken off the floor due to an allegation of verbal abuse. The RN responded with the verbal statement; Resident #7 had already received their medication and the resident was just bugging the RN for more medication. The DON called Resident #19's family member and took their statement. The DON explained Resident #19's room was very close to the nurse's station and the interaction was overheard by Resident #19. Resident #19's family member requested Resident #19 not be cared for by the RN due to witnessing the RN cursing and throwing items around the nurse's station. The DON confirmed the incident was witnessed by a staff member and a visitor of the facility. The DON confirmed the DON did not interview Resident #19 or the resident the CNA noted in their statement regarding the incident. On 04/05/2024 at 10:30 AM, the Administrator verbalized the Administrator was not able to substantiate the allegation of verbal abuse. The Administrator reviewed the facility footage, and it appeared the RN was venting, and the venting was not directed at Resident #7. The RN was terminated for misconduct for being inappropriate in the workplace due to the incident. The Administrator verbalized Resident #7 did not experience psychosocial harm; the trauma screening was negative, and the resident verbalized the resident was fine and showed no signs of distress. The Administrator verbalized the statement from Resident #19's family member was not included in the FRI investigation documentation. The Administrator explained if the statement was not included in the FRI investigation packet and the residents mentioned by the CNA that witnessed the incident were not interviewed, the Administrator would not consider it to be a complete investigation. The Administrator confirmed Resident #19 and the other resident noted by the CNA were not interviewed and the investigation was not complete. The facility policy titled Abuse Investigation and Reporting, adopted 02/01/19, documented all reports of resident abuse would be thoroughly investigated by facility management. The individual conducting the investigation would interview any witnesses to the incident. Witness reports would be obtained in writing. Upon conclusion of the investigation, the investigator would record the results of the investigation in approved documentation forms and provide the completed documentation to the Administrator. FRI #NV00070435

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848 Based on interview, record review, and document review, the facility failed to ensure the policy pertaining to abuse investigations and reporting was implemented. An allegation of abuse was not investigated or reported to law enforcement or the State agency for 1 of 18 sampled residents (Resident #2) placing the resident at continued risk of physical abuse by a staff member. Findings include: Resident #2 Resident #2 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic (diastolic) congestive heart failure, type 2 diabetes mellitus with diabetic neuropathy, unspecified, and anxiety disorder, unspecified. An Adult Protective Services (APS) report documented an APS Social Worker (SW) met with Resident #2 on 12/08/2023 and the resident had informed the SW a CNA had handled the resident roughly when providing care and had slapped the resident on the cheek. The APS SW discussed the incident, including the name of the CNA, the resident alleged to be the perpetrator, with the Administrator of the facility. On 04/04/2024 at 12:34 PM, the Administrator/Abuse Coordinator (AC) verbalized the Administrator/AC recalled the visit from the APS SW. The Administrator/AC verbalized the APS SW had informed the Administrator/AC Resident #2 alleged the CNA was rough when handling the resident. The Administrator/AC verbalized the Director of Nursing (DON) had completed the bulk of the investigation and the allegation was not substantiated. The Administrator/AC verbalized a final report would have been submitted to the State agency within five working days. On 04/04/2024 at 12:47 PM, the Administrator/AC and the DON verbalized the abuse allegation made by Resident #2 was not investigated and was not reported to the State agency or law enforcement. The Administrator/AC verbalized the incident was not investigated because the resident had a history of unfounded allegations. The Administrator/AC explained the facility was required to investigate all new allegations of abuse. On 04/04/2024 at 12:52 PM, the DON verbalized Resident #2 was in a room on the 300 hall. On 04/04/2024 at 2:02 PM, the DON confirmed the CNA continued to work on the 300 hall after Resident #2 had made the allegation of abuse and the CNA had worked directly with Resident #2. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The facility policy titled Abuse Investigation and Reporting, adopted 02/01/2019, documented all reports of resident abuse would be promptly reported, within two hours for alleged violations of abuse, to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. The Administrator would immediately suspend any employee who had been accused of resident abuse, pending the outcome of the investigation. The Administrator would ensure any further potential abuse, neglect, exploitation, or mistreatment was prevented. The Administrator would provide the appropriate agencies with a written report of the findings of the investigation within five working days of the occurrence of the incident.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848 Based on interview, record review, and document review, the facility failed to ensure an allegation of physical abuse against a resident by a staff member was reported within the two-hour time frame for 1 of 18 sampled residents (Resident #2). This deficient practice could allow allegations of abuse to occur and not be reported for investigation. Findings include: Resident #2 Resident #2 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic (diastolic) congestive heart failure, type 2 diabetes mellitus with diabetic neuropathy, unspecified, and anxiety disorder, unspecified. An Adult Protective Services (APS) report documented an APS Social Worker (SW) met with Resident #2 on 12/08/2023 and the resident had informed the SW a CNA had handled the resident roughly when providing care and had slapped the resident on the cheek. The APS SW discussed the incident, including the name of the CNA, the resident alleged to be the perpetrator, with the Administrator of the facility. On 04/04/2024 at 12:34 PM, the Administrator/Abuse Coordinator (AC) verbalized the Administrator/AC recalled the visit from the APS SW. The Administrator/AC verbalized the APS SW had informed the Administrator/AC Resident #2 alleged the CNA was rough when handling the resident. The Administrator/AC verbalized the Director of Nursing (DON) had completed the bulk of the investigation and the allegation was not substantiated. The Administrator/AC verbalized a final report would have been submitted to the State agency within five working days. On 04/04/2024 at 12:47 PM, the Administrator/AC and the DON verbalized the abuse allegation made by Resident #2 was not investigated and was not reported to the State agency or law enforcement. The Administrator/AC verbalized the incident was not investigated because the resident had a history of unfounded allegations. The Administrator/AC explained the facility was required to investigate all new allegations of abuse. The facility policy titled Abuse Investigation and Reporting, adopted 02/01/2019, documented all reports of resident abuse would be promptly reported, within two hours for alleged violations of abuse, to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. The Administrator would immediately suspend any employee who had been accused of resident abuse, pending the outcome of the investigation. The Administrator would ensure any further potential abuse, neglect, exploitation, or mistreatment was prevented. The Administrator would provide the appropriate agencies with a written report of the findings of the investigation within five working days of the occurrence of the incident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848 Based on interview, record review, and document review, the facility failed to investigate a resident's allegation of abuse for 1 of 18 sampled residents (Resident #2). Resident #2 alleged a Certified Nursing Assistant (CNA) slapped the resident and handled the resident roughly when providing care. The CNA named in the abuse allegation was scheduled to work with the resident of concern and throughout the facility from the time the facility was made aware of the allegation on [DATE], until [DATE]. The facility did not report the incident to the State Survey Agency or law enforcement. The lack of investigation and measures to prevent further potential abuse allowed the alleged perpetrator continued access, with the potential for further physical abuse and harm, to the alleged victim and all residents within the CNA's assignment. Furthermore, the facility failed to conduct a thorough investigation into an allegation of a Registered Nurse (RN) verbally abusing a resident for 1 of 18 sampled residents (Resident #7). On [DATE] at 3:24 PM, the Administrator was notified of Immediate Jeopardy (IJ) related to the failure to investigate and report an allegation of abuse and failure to protect Resident #2 and all residents included in the assignments for the alleged perpetrator. The IJ began on [DATE], when the facility was made aware of the allegations of abuse by Resident #2, including being slapped by the CNA and the CNA was rough when providing care. The lack of investigation into the allegations and protection of residents (suspending the CNA during an investigation into the allegations) had the potential to result in physical abuse and cause harm to all residents within the CNA's assignment. Findings include: Resident #2 Resident #2 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic (diastolic) congestive heart failure, type 2 diabetes mellitus with diabetic neuropathy, unspecified, and anxiety disorder, unspecified. The resident expired on [DATE]. An Adult Protective Services (APS) report, dated [DATE], documented an APS Social Worker (SW) met with Resident #2 on [DATE] and the resident had informed the SW a CNA had handled the resident roughly when providing care and had slapped the resident on the cheek. The APS SW discussed the incident, including the name of the CNA the resident alleged to be the perpetrator, with the Administrator of the facility on [DATE]. On [DATE] at 12:34 PM, the Administrator/Abuse Coordinator (AC) verbalized the Administrator/AC recalled the visit from the APS SW. The Administrator/AC verbalized the APS SW had informed the Administrator/AC Resident #2 alleged the CNA was rough when handling the resident. The Administrator/AC verbalized the Director of Nursing (DON) had completed the bulk of the investigation and the allegation was not substantiated. The Administrator/AC verbalized a final report would have been submitted to the State agency within five working days. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 12:47 PM, the Administrator/AC and the DON verbalized the abuse allegation made by Resident #2 was not investigated and was not reported to the State agency or law enforcement. The Administrator/AC verbalized the incident was not investigated because the resident had a history of unfounded allegations. The Administrator/AC explained the facility was required to investigate all new allegations of abuse. The facility Staffing Record documented the CNA named in the abuse allegation had continued to work the [NAME] Wing 300 unit for 20 days in [DATE] days in [DATE] days in February 2024, and 25 days in [DATE]. On [DATE] at 2:02 PM, the DON confirmed the CNA continued to work on the 300 halls after Resident #2 had made the allegation of abuse and the CNA had worked directly with Resident #2. The facility policy titled Abuse Investigation and Reporting, adopted [DATE], documented all reports of resident abuse would be promptly reported, within two hours for alleged violations of abuse, to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. The Administrator would immediately suspend any employee who had been accused of resident abuse, pending the outcome of the investigation. The Administrator would ensure any further potential abuse, neglect, exploitation, or mistreatment was prevented. The Administrator would provide the appropriate agencies with a written report of the findings of the investigation within five working days of the occurrence of the incident. 34524 Resident #7 Resident #7 was admitted to the facility on [DATE], with diagnoses including unspecified chronic bronchitis, unspecified severe protein calorie malnutrition, and depression. Resident #19 Resident #19 was admitted to the facility on [DATE], with a diagnosis of paroxysmal atrial fibrillation. A Facility Reported Incident (FRI) documented on [DATE], the allegation a staff member was witnessed verbally berating a resident at the nurse's station. A Nursing Note dated [DATE], documented the Director of Nursing (DON) received a telephone call from a Certified Nursing Assistant (CNA) who, along with a family member of a resident witnessed a Registered Nurse (RN) verbally berate Resident #7 at the nurse's station. The nurse was cursing and throwing medication bottles around the nurses' station. Comments were aimed at the resident, per the CNA and the family member statement. The on-call manager was notified, and the nurse was relieved, taken off the floor and sent home. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A statement from the DON dated [DATE], documented the DON received a phone call from a CNA requesting the DON contact Resident #19's family member regarding the way an RN was treating a resident at the nurse's station. The DON called Resident #19's family member and the family member stated they were concerned because the RN was being very unprofessional; cursing and using terrible language that could be overheard down the hall. The family member was visiting Resident #19 when they heard the incident. The family member poked their head out of the door and looked down the hall and saw a resident sitting in a wheelchair at the nurse's station. The family member was not sure if the RN was yelling at the resident or just cursing in general and throwing items around the nurse's station. The family member asked the DON to not have the RN care for Resident #19 any longer. On [DATE] at 11:05 AM, during a telephone interview, a CNA verbalized the CNA was at the nurse's station speaking with another resident's family member when the RN began yelling at Resident #7 at the nurse's station regarding medication. The RN was saying you can take the whole bottle, I don't care, it's not going to kill you. The RN was yelling and slamming medication containers down. Resident #19 resided down the hall from the nurse's station. Resident #19's family member heard the yelling and came out to the hall. The family member was concerned as their minor child was in the room and could hear the cursing. The family member asked the nurse not to provide care to Resident #19 any longer. On [DATE] at 10:20 AM, the Administrator verbalized FRI investigation documentation should include interviews with the alleged staff and residents and staff involved or affected by the incident. The Administrator explained the Administrator and the DON shared the responsibility of Abuse Coordinator. The DON was notified of the allegation and completed the initial report, interviewed staff who witnessed the incident, suspended the alleged employee, and ensured trauma screening was completed. On [DATE] at 10:21 AM, the DON confirmed the incident was witnessed by a staff member and a visitor of the facility. The DON confirmed the DON did not interview Resident #19 or the resident the CNA noted in their statement regarding the incident. On [DATE] at 10:30 AM, the Administrator verbalized the statement from Resident #19's family member was not included in the FRI investigation documentation. The Administrator explained if the statement was not included in the FRI investigation packet and the residents mentioned by the CNA that witnessed the incident were not interviewed, the Administrator would not consider it to be a complete investigation. The Administrator confirmed Resident #19 and the other resident noted by the CNA were not interviewed and the investigation was not complete. FRI #NV00070435

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848 Based on observation, interview, record review, and document review, the facility failed to ensure a Licensed Practical Nurse (LPN) had the competencies necessary to safely perform medication administration for 1 of 2 nurses observed for medication administration observations. Findings include: On 04/04/2024 at 7:22 AM, an LPN was administering medications to residents on the 400 hall. Three clear plastic cups containing a clear liquid were sitting on top of the medication cart. The LPN verbalized the LPN had premixed 17-gram doses of the Polyethylene Glycol 3350 (MiraLAX) and stored the doses on top of the cart. The LPN confirmed the cups containing the MiraLAX had the same appearance as cups of plain water and could have been ingested by other residents or visitors. On 04/04/2024 at 7:30 AM, the LPN entered room [ROOM NUMBER] and two cups of the MiraLAX solution remained on top of the medication cart in the hallway out of the view of the LPN. On 04/04/2024 at 7:36 AM, the LPN entered room [ROOM NUMBER] and two cups of the MiraLAX solution remained on top of the medication cart in the hallway out of the view of the LPN. On 04/04/2024 at 7:44 AM, the LPN entered room [ROOM NUMBER] with one of the cups of the MiraLAX solution. One cup of the MiraLAX solution remained on top of the medication cart in the hallway out of the view of the LPN. On 04/04/2024 at 7:53 AM, the LPN entered room [ROOM NUMBER] and one cup of the MiraLAX solution remained on top of the medication cart in the hallway out of the view of the LPN. On 04/04/2024 at 9:42 AM, the Director of Nursing (DON) verbalized medications would not be left on top of a medication cart as anybody could walk by the medication cart and take the medications. The DON verbalized medications were prepared for one resident at a time and would not be premixed. On 04/04/2024 at 9:59 AM, the Director of Nursing (DON) verbalized the facility did not require competency checklists for new nurses and did not have a medication administration competency checklist for the LPN.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848 Based on observation, interview, record review, and document review, the facility failed to ensure a resident's medications were administered as ordered and not left at the bedside for 1 of 18 sampled residents (Resident #1). Bedtime medications from 04/02/2024 and morning medications from 04/03/2024 were left at the bedside of the resident for the resident to take without staff supervision for a total of 10 out of 10 medications not administered as ordered, creating the potential for oversedation and a higher risk of drug-to-drug interactions. The medication error rate was 100 percent (%). Findings include: Resident #1 Resident #1 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphagia following cerebral infarction, and major depressive disorder, single episode, mild. On 04/03/2024 at 9:00 AM, Resident #1 was laying in bed and two medication cups were on the resident's bedside table. One medication cup contained six pills and the other contained four pills. On 04/03/2024 at 9:13 AM, a Licensed Practical Nurse (LPN)1 verbalized Resident #1 would ask staff to leave medications at the bedside and confirmed one of the cups contained Melatonin (a medication administered for sleep). On 04/03/2024 at 9:15 AM, the LPN2 for Resident #1 confirmed the medication cups on the resident's bedside table contained the following medications marked as administered on the Medication Administration Record (MAR): - Medication cup #1 contained a 5 milligram (mg) tablet of Baclofen, a 5 mg tablet of Buspirone HCl, two 3 mg tablets of Melatonin, an 8.6-50 mg tablet of Senokot S, and a 10 mg tablet of Simvastatin. All were documented as administered during the bedtime medication pass on 04/02/2024. - Medication cup #2 contained a 5 mg tablet of Baclofen, a 5 mg tablet of Lisinopril, an 8.6-50 mg tablet of Senokot S, and a 100 mg tablet of Venlafaxine. All were documented as administered during the morning medication pass on 04/03/2024. LPN2 verbalized the medications should not have been documented as administered if the resident had not yet taken the medications. The LPN2 verbalized the LPN2 was not supposed to leave medications with a resident and was supposed to make sure the resident took all medications at the time ordered as the resident could be at risk of overdosing. Resident #1 had the following medication orders: - Baclofen oral tablet 5 mg, take one tablet by mouth at bedtime for pain management related to right foot muscle spasm with a start date of 03/13/2024. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Baclofen oral tablet 5 mg, give one tablet by mouth in the morning for pain management related to right foot muscle spasm with a start date of 03/13/2024. - Buspirone hydrochloride (HCl) 5 mg, give one tablet by mouth at bedtime for anxiety with a start date of 02/05/2024. - Lisinopril oral tablet 5 mg, give one tablet by mouth in the morning for hypertension with a start date of 12/13/2023. - Melatonin oral tablet 3 mg, give two tablets by mouth at bedtime for delayed onset of sleep with a start date of 12/13/2023. - Senokot S oral tablet 8.6-50 mg, give one tablet by mouth at bedtime for bowel management with a start date of 12/14/2023. - Senokot S oral tablet 8.5-50 mg, give one tablet by mouth in the morning for bowel management with a start date of 12/15/2023. - Simvastatin oral tablet 10 mg, give 10 mg by mouth at bedtime for hyperlipidemia with a start date of 12/13/2023. - Venlafaxine HCl oral tablet 100 mg, give one tablet by mouth in the morning for depression with a start date of 12/13/2023. The April 2024 MAR for Resident #1 documented the following: - Baclofen 5 mg tablets were administered with bedtime medications on 04/02/2024, and with morning medications on 04/03/2024. - Buspirone HCl 5 mg tablet was administered with bedtime medications on 04/02/2024. - Lisinopril 5 mg tablet was administered with morning medications on 04/03/2024. - Melatonin 3 mg tablets, two tablets were administered with bedtime medications on 04/02/2024. - Senokot S Oral Tablet 8.6-50 mg tablet was administered with bedtime medications on 04/02/2024 and was administered with morning medications on 04/03/2024. - Simvastatin 10 mg tablet was administered with bedtime medications on 04/02/2024. - Venlafaxine HCl 100 mg tablet was administered with morning medications on 04/03/2024. On 04/04/2024 at 2:44 PM, the Physician for Resident #1 verbalized the Physician expected medications to be given at the ordered time. The Physician explained it would be a high risk practice to leave both bedtime and morning medications at the bedside and would interfere with the specific reasons the medications were ordered and place the resident at a higher risk of drug to drug interactions. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Liberalized Medication Administration, created February 2023, documented the general nursing standard of practice for medication administration would remain in place including the five rights of medication administration. The National Institute of Health documented the five rights of medication administration for nursing practice, generally regarded as a standard for safe medication practices, included administration of medications at the right time.

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F 0761 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848 Based on observation, interview, and document review the facility failed to ensure cups containing a laxative powder dissolved in cups of water, were not stored on the top of the medication cart when not in sight of a staff member with the potential for the medication to be ingested by other residents or visitors for 3 of 3 premixed cups of the medication and unlocked medication carts were not left unattended. The laxative powder had potential common side effects including bloating, gas, upset stomach, and dizziness. Findings include: On 04/04/2024 at 7:22 AM, a Licensed Practical Nurse (LPN) was administering medications to residents on the 400 hall. Three clear plastic cups containing a clear liquid were sitting on top of the medication cart. The LPN verbalized the LPN had premixed 17-gram doses of the Polyethylene Glycol 3350 (MiraLAX) and stored the doses on top of the cart. The LPN confirmed the cups containing the MiraLAX had the same appearance as cups of plain water and could have been ingested by other residents or visitors. On 04/04/2024 at 7:30 AM, the LPN entered room [ROOM NUMBER] and two cups of the MiraLAX solution remained on top of the medication cart in the hallway out of the view of the LPN. On 04/04/2024 at 7:36 AM, the LPN entered room [ROOM NUMBER] and two cups of the MiraLAX solution remained on top of the medication cart in the hallway out of the view of the LPN. On 04/04/2024 at 7:44 AM, the LPN entered room [ROOM NUMBER] with one of the cups of the MiraLAX solution. One cup of the MiraLAX solution remained on top of the medication cart in the hallway out of the view of the LPN. On 04/04/2024 at 7:53 AM, the LPN entered room [ROOM NUMBER] and one cup of the MiraLAX solution remained on top of the medication cart in the hallway out of the view of the LPN. On 04/04/2024 at 9:42 AM, the Director of Nursing (DON) verbalized medications would not be left on top of a medication cart as anybody could walk by the medication cart and take the medications. The DON verbalized medications were prepared for one resident at a time and would not be premixed. The facility policy titled Storage of Medications, adopted on 02/01/2019, documented drugs would be stored in the packaging, containers, or other dispensing systems in which they were received. The nursing staff would be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Drugs would be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications would be assigned to an individual cubicle, drawer, or the holding area to prevent the possibility of mixing medications of several residents. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	34524 Unsecured Medications On 04/04/2024 at 10:07 AM, a medication cart in the 300/400 hall was unlocked. Thirteen staff, residents, and visitors walked past the unsecured medication cart. On 04/04/2024 at 10:12 AM, a Registered Nurse (RN) noticed the cart was unlocked and came to stand in front of the medication cart. The RN verbalized the medication cart should be locked and confirmed the facility had residents with dementia that wander in the facility and could access the unsecured medications. The RN confirmed multiple staff, residents and visitors walked past the open medication cart. On 04/04/2024 at 10:14 AM, a LPN1 returned to the medication cart and stated the medication cart was their responsibility. The LPN confirmed the medication cart was unlocked and the medications unsecured. On 04/04/2024 at 11:57 AM, a medication cart outside of room [ROOM NUMBER] was unlocked and the medications in the cart were unsecured. Three people walked past the unlocked medication cart. On 04/04/2024 at 11:59 AM, LPN2 returned to the unsecured medication cart and verbalized they were responsible for the medication cart and the medication cart should be locked when a staff member was not using it.