

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Alta Skilled Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848</p> <p>Based on interview, clinical record review, and document review, the facility failed to ensure a resident's representative and the resident's physician was notified of a change in the resident's condition for 1 of 3 sampled residents reviewed for closed records (Resident #305). This deficient practice had the potential to result in a resident's representative and physician being unaware of significant decline in a resident's physical well-being and the resident suffering physical harm without family support or medical intervention.</p> <p>Findings include:</p> <p>Resident #305</p> <p>Resident #305 was admitted to the facility on [DATE], and discharged on [DATE], with diagnoses including other pulmonary embolism without acute cor pulmonale, other specified peripheral vascular diseases, cognitive communication deficit, and disturbance, psychotic disturbance, mood disturbance, and anxiety.</p> <p>A Skin/Wound Note, dated 04/30/2024, documented the Nurse noticed bluish discoloration to the resident's right lower extremity. The affected area was cold and clammy with positive pedal pulses. The resident was experiencing generalized pain due to contracture of the right leg. The Nurse called the Physician to relay the condition. The Physician ordered a bilateral leg arterial ultrasound.</p> <p>A physician order dated 04/30/2024, documented bilateral leg arterial ultrasound.</p> <p>A Weekly Skin Check for Resident #305, dated 05/01/2024, documented the resident had bluish discoloration and cold, clammy skin to the resident's right lower leg and the leg was starting to be painful. The Physician was notified on 04/30/2024, and a bilateral arterial ultrasound was ordered.</p> <p>An Appointment Note, dated 05/03/2024, documented a transport request was placed for bilateral lower extremity ultrasound as the facility's current contracted diagnostics company did not have an ultrasound technician.</p> <p>(continued on next page)</p>

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Alta Skilled Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Monthly Nursing Summary for Resident #305, dated 05/04/2024, documented the resident had increased pain to bilateral lower extremities, cold, clammy skin, and bluish discoloration to the right lower extremity. The resident likely had some circulatory problem. The resident now had complaints of 10 out of 10 pain. The physician had ordered an arterial ultrasound of bilateral lower extremities but there was no in house ultrasound available.</p> <p>A Nursing Note, dated 05/06/2024, documented the facility's contracted diagnostics company was called to see if they still did not have an ultrasound technician and the company confirmed they did not have one. A request was made to transport to see if the resident could go to an outpatient imaging center. The resident's right lower extremity had blue discoloration and was painful to touch. The Unit Manager (UM) advised the nurses to call the Physician if the resident's leg became worse.</p> <p>A Behavior Note, dated 05/06/2024, documented the resident kept yelling and screaming.</p> <p>A Transfer to Hospital Summary, dated 05/07/2024, documented the resident had an order for an arterial ultrasound of bilateral lower extremities related to swelling and discoloration. The ultrasound could not be completed in the facility. The Physician was notified and ordered the resident sent to the hospital. The resident's representative was notified of the situation. The resident was sent to the hospital via emergency transport.</p> <p>On 06/11/2024 at 10:04 AM, the UM verbalized the resident's nurse had reported to the UM on 04/30/2024, the resident had discoloration of the resident's leg and the discoloration did not improve when the leg was elevated. The UM verbalized the Physician had ordered an ultrasound, but the facility's contracted ultrasound provider did not have an ultrasound technician. The UM confirmed the family was not notified of changes between 04/30/2024 and 05/07/2024.</p> <p>On 06/11/2024 at 10:46 AM, the Director of Nursing (DON) verbalized the DON did not see any documentation the Physician had been notified of the lack of an ultrasound technician and the inability to have the ultrasound completed in the facility.</p> <p>On 06/11/2024 at 10:58 AM, the Physician verbalized the facility had not informed the Physician the resident was declining while awaiting an ultrasound. The Physician verbalized if the Physician had been notified of the resident's clinical decline and the unavailability of a bedside ultrasound, the Physician would have ordered for the resident to be sent to the hospital with no delay.</p> <p>The facility policy titled, Change in a Resident's Condition or Status, adopted 02/01/2019, documented, the facility would promptly notify the resident, the healthcare provider, and the resident representative of changes in the resident's medical condition and status. The nurse would notify the Physician when there was a significant change in the resident's condition, the need to transfer the resident to a hospital, or when there were specific instructions to notify the Physician of changes in the resident's condition. A nurse would notify the resident's representative when there was a significant change in the resident's physical status.</p> <p>Complaint #NV00071241</p> <p>Cross reference with tags F600 and F849</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Alta Skilled Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848</p> <p>Based on interview, clinical record review, and document review, the facility failed to ensure a resident was not physically abused by another resident for 2 of 2 residents investigated for resident to resident abuse (Resident #83 and #122).</p> <p>Findings include:</p> <p>The facility policy titled Abuse Prevention Program, adopted 02/01/2019, documented residents had the right to be free from neglect.</p> <p>The Centers for Disease Control and Prevention defines neglect in older persons as the failure to meet an older adult's basic needs. These needs include essential medical care.</p> <p>Complaint #NV00071241</p> <p>Cross reference with tags F580 and F849</p> <p>31739</p> <p>Resident to Resident Abuse</p> <p>Resident #83</p> <p>Resident #83 was admitted to the facility on [DATE], and readmitted [DATE], with diagnoses including schizophrenia, unspecified, and anxiety disorder with irritability and anger.</p> <p>An Incident Note dated 04/09/2024, documented a nurse had heard Resident #83 screaming and cursing while an aide had witnessed Resident #83 spit on and throw a cup with water at the resident's roommate while the roommate was lying in bed, asleep (Resident #122).</p> <p>Resident #83's Care Plan dated 05/25/2020, documented the resident had the potential for disruptive behaviors, and to monitor for inappropriate language around other residents and intervene as necessary. Care Plan dated 06/08/2023, documented the resident had demonstrated verbally aggressive behaviors towards others related to schizophrenia diagnosis and to administer medications as ordered and monitor and document for side effects and effectiveness.</p> <p>A physician's order dated 04/10/2024, documented Resident #83 may be discharged to behavioral health center today, when bed was available.</p> <p>Resident #122</p> <p>Resident #122 was admitted to the facility on [DATE], with diagnoses including epilepsy, unspecified, and dysphagia, oropharyngeal phase.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Alta Skilled Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An Incident Note dated 04/09/2024, documented Resident #122 had been asleep when Resident #83 spit on and threw water on the resident. The residents were separated, and the nurse manager was informed. Plan to move Resident #122 to another room.</p> <p>A Communication Note dated 04/10/2024, documented the social worker had met with Resident #122 to follow up on the room change. The resident verbalized to the social worker the resident had slept well and, just had to get out of there, referring to the old room.</p> <p>On 06/13/2024 at 10:51 AM, the DON confirmed Resident #83 had spit on and thrown a cup of water on Resident #122. The DON verbalized Resident #83 had been receiving behavior health services prior to the altercation and the facility had not been able to implement any new interventions due to Resident #83's increased behaviors; Resident #83 was transferred to a behavioral health center for additional services, and Resident #122 was moved to another room.</p> <p>The facility policy titled, Abuse Prevention Program, adopted 02/01/2019, documented as part of the resident abuse prevention program, the facility would protect residents from abuse by anyone, including other residents.</p> <p>FRI #NV00070898</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Alta Skilled Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43311</p> <p>Based on observation, interview, clinical record review, and document review, the facility failed to provide protective supervision when a resident wearing a wander device followed an employee out of an alarmed exit door, the alarm system failed to work, and the resident was found wandering around in the parking lot for 1 of 1 residents investigated for elopement (Resident #411).</p> <p>Findings include:</p> <p>Resident #411</p> <p>Resident #411 was admitted to the facility on [DATE], and discharged on [DATE], with diagnoses including metabolic encephalopathy, cognitive communication deficit, and need for assistance with personal care.</p> <p>A Facility Reported Incident (FRI) #NV00070899 dated 04/08/2024, documented Resident #411's significant other found the resident wandering in the parking lot and brought the resident back into the facility. Video footage review showed Resident #411 had followed a Certified Nursing Assistant (CNA) out of the East exit door at 2:46 PM. The resident wore a Wanderguard device and the alarm failed to sound when the resident exited the building.</p> <p>An Elopement Risk Evaluation dated 04/03/2024, documented Resident #411 was at moderate risk for wandering based on forgetfulness or had a short attention span and was a known wanderer or had a history of wandering.</p> <p>A Device Enabler Evaluation dated 04/03/2024, documented Resident #411 was using a Wanderguard device. The device use reason was documented as the resident was confused, wandered around the facility, and was at risk for elopement.</p> <p>Resident #411's care plan initiated on 04/03/2024, documented the following focus:</p> <ul style="list-style-type: none"> -The resident was an elopement risk/wanderer related to a history of attempts to leave the facility unattended, impaired safety awareness. -Resident wandered aimlessly. <p>Resident #411's care planned interventions were as follows:</p> <ul style="list-style-type: none"> -Distract resident from wandering by offering pleasant diversions, structured activities, food, conversations, television, books, 04/03/2024. -One on one supervision until Wanderguard obtained, 04/03/2024 -Place Wanderguard to alert staff of Resident's attempts to exit the building, 04/08/2024 <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Alta Skilled Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Wander Alert: Left wrist, 04/08/2024</p> <p>-Provide a photograph of the Resident to the Wanderer's List. There should be a binder for each Nurses' Station and the Front Entrance, 04/03/2024.</p> <p>-When resident needed assistance back to his/her unit, staff had to physically escort him/her. Residents with Dementia were unable to follow complicated directions, 04/03/2024.</p> <p>On 06/11/2024 at 2:02 PM, the DON explained all staff were trained on elopement annually and with in-services. The DON communicated the expectation of the staff to be able to distinguish which residents were safe to go outside of the building. All staff were to ensure residents did not follow the staff out of an exit door and would be expected to re-direct the resident, get the resident to a safe place, and report the situation to a nurse. The DON confirmed the elopement was preventable.</p> <p>On 06/11/2024 at 2:45 PM, the Administrator explained Resident #411 was found in the East parking lot by their family member on 04/08/2024, at approximately 2:46 PM. The Administrator confirmed Resident #411 had followed an employee out of the East exit door and was wearing a Wanderguard device that did not sound the exit alarm. The Administrator explained the investigation revealed all of the alarmed exits had malfunctioned with the Wanderguard devices and did not alarm when a resident wearing the device walked past.</p> <p>The Administrator explained Maintenance was responsible to check the alarm device system weekly but had not found the system was malfunctioning at every exit. The Administrator communicated the exit alarm system was replaced to correct the malfunctioning system.</p> <p>The facility policy titled, Wandering and Elopements, adopted 02/01/2019, documented the facility would identify residents who were at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment. If an employee observed a resident leave the premises, the employee would: attempt to prevent the resident from leaving in a courteous manner, get help from another staff member in the immediate vicinity, and instruct another staff member to inform the Charge Nurse or Director of Nursing Services that a resident was attempting to leave or has left the premises.</p> <p>FRI #NV00070899</p>