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	06/13/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848 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. Findings include: Resident #305 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. 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. A physician order dated 04/30/2024, documented bilateral leg arterial ultrasound. 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. 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. (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. A Behavior Note, dated 05/06/2024, documented the resident kept yelling and screaming. 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. 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. 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. 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. 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. Complaint #NV00071241 Cross reference with tags F600 and F684

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34524 Based on observation, interview, clinical record, and document review, the facility failed to provide a comfortable, homelike environment when the facility was made aware of a broken air conditioning (AC) unit in a resident room and did not act to fix the unit or offer an accommodation to the resident for 1 of 33 sampled residents (Resident #257). Findings include: Resident #257 Resident #257 was admitted to the facility on [DATE], with diagnoses including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and unspecified systolic congestive heart failure. On 06/10/2024 at 1:08 PM, Resident #257's spouse verbalized the resident's room was often hot. They recalled they informed the Administrator earlier in the day and the Administrator told the resident's spouse they would consider moving the resident to a different room. On 06/13/2024 at 11:05 AM, Resident #257's spouse verbalized the AC unit in the room was broken and had been broken for three days. The spouse recalled they informed the staff three days prior the AC was not working, and it was hot in the room. The spouse further explained when staff entered the room, they would remark it was warm in here. On 06/13/2024 at 11:06 AM, a Licensed Practical Nurse (LPN) verbalized the LPN was not aware of the broken AC unit in Resident #257's room. The LPN explained the LPN would not offer a fan because it was their understanding nothing could be plugged into the outlets in the room. The LPN verbalized when equipment, such as the AC unit, was broken, staff would put in a request to maintenance for the equipment to be fixed. Staff would consider moving the resident to another room for their comfort until the AC could be fixed. The LPN was not aware if a request had been made to maintenance or if the resident was to be moved to another room in the interim. On 06/13/2024 at 11:10 AM, the Head Operations Manager (HOM) verbalized when equipment was broken, staff would put a work order request into the electronic system. The HOM recalled the HOM was made aware of the broken AC unit in Resident #257's room two days prior. There were no available units in the facility and an AC unit had to be ordered from the home office. The HOM verbalized the AC unit had arrived and the HOM would be replacing the AC unit today. On 06/13/2024 at 11:24 AM, the LPN turned on the AC unit in Resident #257's room and confirmed the unit was blowing warm air. The LPN verbalized it was warm in the room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/13/2024 at 11:25 AM, the HOM verbalized there was no restriction for plugging a fan into an outlet in a resident's room and they had never heard or given the direction that fans were not allowed to be used in a resident's room. The HOM did not have a working thermometer to measure the temperature in the room, however the HOM verbalized it was much warmer in Resident #257's room in comparison to other resident rooms and the general temperature of the facility. The HOM verbalized the AC unit had arrived from the home office and was currently being replaced. On 06/13/2024 at 11:31 AM, a Certified Nursing Assistant (CNA) verbalized Resident #257's spouse had informed the CNA two days prior the AC unit was not working. The CNA informed the resident's nurse. The CNA verbalized it was very warm in the resident's room. On 06/13/2024 at 11:36 AM, the Administrator verbalized there was no restriction on fans being plugged into the outlets in the resident's room as long as it did not hinder care. When equipment such as an AC unit was broken, staff would submit a work order request for the unit to be fixed. If it could not be fixed the same day, the accommodation would be to move the resident to another room until the unit was fixed. The Administrator verbalized it would be appropriate to offer the resident a fan and the front desk had desk fans available. The Administrator acknowledged temperatures outside were in the 90's. The Administrator verbalized the resident was not experiencing a comfortable, homelike environment due to the broken AC unit and the temperature in the resident's room. A work order created 06/13/2024 at 11:14 AM, documented the AC unit in Resident #257's room was not working and was blowing warm air. The work order was updated at 11:53 AM and documented the AC unit had been replaced. The HOM was made aware the unit was not working and no work order had been created. The facility did not have any units in inventory and one had to be ordered from the home office. This was the soonest the unit could be installed. On 06/13/2024 at 12:02 PM, the Administrator verbalized the work order for repair of the AC unit in Resident #257's room was not created until 06/13/2024. The facility policy titled, Quality of Life - Homelike Environment, dated 02/01/2019, documented residents were provided with a safe, clean, comfortable, and homelike environment. The facility staff and management should maximize, to the extent possible, the characteristics of the facility which reflect a personalized, homelike environment. These characteristics included comfortable and safe temperatures.

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F 0600 Level of Harm - 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** 41848 Based on interview, clinical record review, and document review, the facility failed to 1) ensure a resident with a deep vein thrombosis (DVT) (a blood clot in one or more of the deep veins in the body) received the necessary care to prevent the resident from developing gangrene in a lower extremity and requiring hospitalization for 1 of 3 residents reviewed for closed records (Resident #305). This deficient practice resulted in a resident suffering the actual harm of loss of blood flow to the resident's lower extremity and caused the resident's representative to have to choose between an above the knee amputation of the resident's lower extremity or having the resident receive end of life care, and 2) 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). Findings include: Resident #305 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. 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. A physician order, dated 04/30/2024, documented bilateral leg arterial ultrasound. 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. 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. A Nursing Note, dated 05/03/2024, documented the resident was confused and crying out. The right lower extremity was cool to touch from mid-calf to toes and was tender to touch. The resident's lower extremity was purplish in color to the pads of the toes. 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. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A Nursing Note, dated 05/06/2024, documented the resident continued to cry out in pain when the resident's right lower extremity was touched or moved during care. 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. A Behavior Note, dated 05/06/2024, documented the resident kept yelling and screaming. 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. The Mayo Clinic document titled Deep vein thrombosis (DVT), dated 06/11/2022, documented leg swelling, leg pain, and change in skin color as possible symptoms of a DVT. The clinical record for Resident #305 lacked documentation of pedal pulses assessed after 04/30/2024. 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 available. The UM verbalized the UM instructed the Nurse to send the resident to the hospital if the resident experienced increased pain or further discoloration of the extremity. The UM explained the UM attempted to get the resident an appointment with an outpatient imaging facility on 05/06/2024, but no appointments were available. The UM verbalized the resident's leg was getting worse and the resident was sent to the hospital on 05/07/2024. The UM verbalized the facility should have sent the resident to the hospital earlier and there was a delay in the care provided to the resident. The UM confirmed the only documented pedal pulse was on 04/30/2024, and pedal pulses should have been monitored at least daily for a suspected DVT. The UM verbalized increasing pain in the leg and discoloration were all symptoms indicative of loss of blood flow. On 06/11/2024 at 10:46 AM, the Director of Nursing (DON) verbalized the resident had an order for an ultrasound on 04/30/2024, and the resident did not receive the ultrasound because the facility's contracted ultrasound provider did not have an ultrasound technician. The DON verbalized the resident should have been sent to the hospital for any changes in condition if the facility could not manage the issue. The DON verbalized continued assessment of the resident would have included assessing for pain and the perfusion to both lower extremities. The DON confirmed the assessment should have included checking pulses. The DON verbalized the resident should have been sent to the hospital when the skin checks on 05/01/2024, documented the resident had cold and clammy skin with bluish discoloration. The 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. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	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 the Physician would expect pedal pulses to be assessed when a resident had a suspected DVT, and an ordered ultrasound was delayed. The Physician verbalized if the Physician had been notified of the resident's clinical decline, including discoloration to the leg and the leg being cool to touch, while awaiting an ultrasound, the Physician would have ordered for the resident to be sent to the hospital with no delay. The documentation from the resident's hospital stay documented the following: - The Emergency Department (ED) to Hospital Admission, dated 05/07/2024, documented the resident was brought in via ambulance from the skilled nursing facility with complaints of a discolored purple and cool to touch leg times one week. Per staff the leg had been getting worse. - Results of an Ultrasound of the right lower extremity, dated 05/07/2024, documented the right common femoral, profunda femoral, superficial femoral, popliteal, peroneal, posterior tibial, and anterior tibial arteries appeared to be occluded. - A Skin Assessment, dated 05/07/2024, documented the resident's right leg was shiny, black, purple, and cold. There was an open area near the right heel. The right leg was dark and discolored from the mid knee down. The right heel and toes were boggy and had black and purple discoloration. The right foot had an open wound. - A Vascular Surgery Consultation, dated 05/07/2024, documented the reason for consultation was a dead right lower extremity. An arterial duplex ultrasound confirmed there was no flow from the common femoral artery down throughout the remainder of the right lower extremity. The leg from the knee down was completely gangrenous (death of body tissue due to a lack of blood flow). The resident had severe dense acute ischemia (inadequate blood supply) of the right lower extremity with gangrenous changes of the lower leg and foot. The resident most likely had suffered an acute thromboembolic event of the right lower extremity sometime in the past few days or maybe a week. The lower extremity had enough time to demarcate (boundary between living and dead tissue) up to the mid knee and the gangrenous changes of the right lower leg and foot were so advanced there was no chance of limb salvage. The resident would either need hospice care or an above the knee amputation. The facility policy titled Abuse Prevention Program, adopted 02/01/2019, documented residents had the right to be free from neglect. 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. Complaint #NV00071241 Cross reference with tags F580 and F684 31739 Resident to Resident Abuse Resident #83 (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #83 was admitted to the facility on [DATE], and readmitted [DATE], with diagnoses including schizophrenia, unspecified, and anxiety disorder with irritability and anger. 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). 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. A physician's order dated 04/10/2024, documented Resident #83 may be discharged to behavioral health center today, when bed was available. Resident #122 Resident #122 was admitted to the facility on [DATE], with diagnoses including epilepsy, unspecified, and dysphagia, oropharyngeal phase. 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. 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. 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. 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. FRI #NV00070898

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848 Based on interview, clinical record review, and document review, the facility failed to ensure a resident's report of missing money was investigated per facility policy for 1 of 33 sampled residents (Resident #149). The deficient practice had the potential to result in missing resident belongings not being recovered or misappropriation of resident property not being investigated by the facility. Findings include: Resident #149 Resident #149 was admitted to the facility on [DATE], with diagnoses including anxiety disorder, unspecified and homelessness unspecified. On 06/12/2024 at 10:02 AM, Resident #149 verbalized, after the resident had been admitted to the facility, the resident had told a Certified Nursing Assistant (CNA) the resident had had 20 dollars in the resident's wallet when the resident admitted to the facility and the 20 dollars was missing. The resident verbalized no facility staff had ever followed up with the resident after the resident had reported the missing money to the CNA. A Progress Note, dated 05/23/2024, documented the resident had stated the resident was missing 20 dollars from the resident's wallet. The resident had stated to the CNA the 20 dollars should have been in the wallet and was in the wallet when the resident came to the facility. The resident's clinical record included a Review and Inventory of Valuable Items, dated 05/30/2024, 12 days after the resident was admitted to the facility and seven days after the resident had reported the missing money to a CNA. The Review and Inventory of Valuable Items documented the resident's wallet did not include any money. On 06/12/2024 at 10:22 AM, a CNA verbalized if a resident reported missing money to the CNA, the CNA would report the concern to the Director of Nursing (DON). The CNA explained the CNA would report the concern verbally and would not complete any paperwork or documentation related to the concern. On 06/12/2024 at 11:50 AM, the DON verbalized the DON was not aware of the resident's report of missing money. The DON explained the correct process for addressing a resident's concern with missing money would be to document the concern as a grievance and Social Services (SS) would follow up with the resident. The DON verbalized a belongings list was completed with all residents within 48 hours of admission to the facility. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/12/2024 at 2:20 PM, the Director of Social Services (DSS) verbalized SS had not followed up with the resident regarding the concern and had not reached out to the resident's nurse, from the evening the resident verbalized the concern, until after the issue was brought to the facilities attention by the survey team, and the SS had not interviewed the CNA the resident had informed of the missing money. The DSS confirmed the SS department had not yet interviewed the resident about the concern. The facility policy titled, Abuse Investigation and Reporting, adopted 02/01/2019, documented all reports of misappropriation of resident property would be thoroughly investigated by facility management. The investigation would include reviewing documentation, interviewing the person reporting the incident, interviewing witnesses to the incident, interview the resident, and interview all staff members (on all shifts) who had contact with the resident during the period of the alleged incident.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848 Based on observation, interview, clinical record review, and document review, the facility failed to ensure a resident with a urinary catheter and the behavior of pulling out the urinary catheter had the resident's urinary catheter care plan revised to include interventions to prevent the resident from continuing to pull out the catheter for 1 of 33 sampled residents (Resident #98). This deficient practice had the potential to result in the resident sustaining further injury from the behavior. Findings include: Resident #98 Resident #98 was admitted to the facility on [DATE], with diagnoses including benign prostatic hyperplasia with lower urinary tract symptoms, urinary tract infection, site not specified, and retention of urine, unspecified. On 06/10/2024 at 9:36 AM, Resident #98 was lying in bed and the resident had a urinary catheter draining to a collection bag at the bedside. On 06/10/2024 at 11:11 AM, the resident's representative verbalized the resident had a urinary catheter and the resident had pulled the catheter out twice since admission to the facility and had to return to the hospital to have a new catheter inserted each time. An Order Review History Report for Resident #98 documented the following: - An order dated 05/23/2024, documented send to emergency room to reinsert Foley (urinary catheter), resident combative. - An order dated 05/27/2024, documented send out to hospital for persistent hematuria (blood in urine) due to catheter with intact balloon pulled out. - An order dated 05/22/2024, documented the resident would be seen for Physical Therapy five to seven times a week for 12 weeks. A Progress Note dated, 05/23/2024, documented the resident had pulled out the resident's Foley. The resident was having gross (large amount) hematuria due to traumatization to the resident's penis. A Progress Note dated, 05/27/2024, documented the resident's catheter came out with the balloon still intact. Bleeding was noted and the resident complained of pain to the resident's penis. A Progress Note dated, 06/12/2024, documented the resident had pulled out the resident Foley and was urinating bright red urine. The indwelling catheter care plan for Resident #98, initiated 06/03/2024, lacked documentation of interventions to address the resident's behavior of repeatedly pulling out the indwelling catheter. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/12/2024 at 3:23 PM, the Licensed Practical Nurse (LPN) for Resident #98 verbalized the resident had pulled the resident's catheter out for the third time earlier in the day. The LPN verbalized the resident used to have a leg strap in place to attach the catheter tubing to the resident's leg with the goal of preventing the resident from pulling the catheter out. The LPN confirmed the resident did not have a leg strap or a StatLock (a stabilization device for catheters) in place when the catheter was pulled out earlier in the day. The LPN verbalized measures to help prevent the resident from repeating the behavior of pulling out the catheter would be documented in the care plan. On 06/12/2024 at 3:54 PM, the Director of Nursing (DON) verbalized Resident #98 had pulled out the resident's indwelling catheter for the third time earlier in the day. The DON verbalized the resident would need interventions documented to try and prevent the resident from repeatedly pulling out the urinary catheter. The DON confirmed the catheter tubing could be anchored to the resident's leg and a StatLock would be used for a resident who was working with physical therapy. The facility policy titled, Care Plan, Comprehensive Person-Centered, adopted 02/01/2019, documented the identification of problem areas and their causes, and developing targeted and meaningful interventions for the resident were the endpoint of the interdisciplinary process. Assessments of residents was ongoing and care plans were revised as information about the resident and the resident's condition changed. Cross reference with tag F684

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848 Based on observation, interview, clinical record review, and document review, the facility failed to ensure 1)a resident with a urinary catheter and the behavior of pulling out the urinary catheter had interventions in place to reduce the risk of the resident continuing the behavior and prevent further physical trauma related to the behavior for 1 of 33 sampled residents (Resident #98), 2) the facility provided care according to the facilities standard of practice to a resident with a deep vein thrombosis (DVT) (a blood clot in one or more of the deep veins in the body) for 1 of 3 residents reviewed for closed records (Resident #305) and 3) a physician's order from hospice was communicated to the facility's physician and the resident received an ordered medication for 1 of 33 sampled residents (Resident #455). This deficient practice had the potential to result in the resident sustaining further injury to the resident's lower urinary tract and residents having significant adverse health outcomes from delayed treatment for a DVT. Findings include: Resident #98 Resident #98 was admitted to the facility on [DATE], with diagnoses including benign prostatic hyperplasia with lower urinary tract symptoms, urinary tract infection, site not specified, and retention of urine, unspecified. On 06/10/2024 at 9:36 AM, Resident #98 was lying in bed and the resident had a urinary catheter draining to a collection bag at the bedside. On 06/10/2024 at 11:11 AM, the resident's representative verbalized the resident had a urinary catheter and the resident had pulled the catheter out twice since admission to the facility and had to return to the hospital to have a new catheter inserted each time. An Order Review History Report for Resident #98 documented the following: - An order dated 05/23/2024, documented send to emergency room to reinsert Foley (urinary catheter), resident combative. - An order dated 05/27/2024, documented send out to hospital for persistent hematuria (blood in urine) due to catheter with intact balloon pulled out. - An order dated 05/22/2024, documented the resident would be seen for Physical Therapy five to seven times a week for 12 weeks. A Progress Note dated, 05/23/2024, documented the resident had pulled out the resident's Foley. The resident was having gross (large amount) hematuria due to traumatization to the resident's penis. A Progress Note dated, 05/27/2024, documented the resident's catheter came out with the balloon still intact. Bleeding was noted and the resident complained of pain to the resident's penis. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Progress Note dated, 06/12/2024, documented the resident had pulled out the resident Foley and was urinating bright red urine. The indwelling catheter care plan for Resident #98, initiated 06/03/2024, lacked documentation of interventions to address the resident's behavior of repeatedly pulling out the indwelling catheter. On 06/12/2024 at 3:23 PM, the Licensed Practical Nurse (LPN) for Resident #98 verbalized the resident had pulled the resident's catheter out for the third time earlier in the day. The LPN verbalized the resident used to have a leg strap in place to attach the catheter tubing to the resident's leg with the goal of preventing the resident from pulling the catheter out. The LPN confirmed the resident did not have a leg strap or a StatLock (a stabilization device for catheters) in place when the catheter was pulled out earlier in the day. The LPN verbalized measures to help prevent the resident from repeating the behavior of pulling out the catheter would be documented in the care plan. On 06/12/2024 at 3:54 PM, the Director of Nursing (DON) verbalized Resident #98 had pulled out the resident's indwelling catheter for the third time earlier in the day. The DON verbalized the resident would need interventions documented to try and prevent the resident from repeatedly pulling out the urinary catheter. The DON confirmed the catheter tubing could be anchored to the resident's leg and a StatLock would be used for a resident who was working with physical therapy. The facility policy titled Catheter Care, Urinary, adopted 02/01/2019, documented the catheter would be secured with a leg strap to reduce friction and movement at the insertion site. Catheter tubing would be strapped to the resident's inner thigh. Cross reference with tag F657 Resident #305 Resident #305 was admitted to the facility on [DATE], and discharged [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. 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. A physician order, dated 04/30/2024, documented bilateral leg arterial ultrasound. 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. A Nursing Note, dated 05/03/2024, documented the resident was confused and crying out. The right lower extremity was cool to touch from mid-calf to toes and was tender to touch. The resident's lower extremity was purplish in color to the pads of the toes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. A Nursing Note, dated 05/06/2024, documented the resident continued to cry out in pain when the resident's right lower extremity was touched or moved during care. 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. The resident right lower extremity had blue discoloration and was painful to touch. The Unit Manager advised the nurses to call the Physician if the resident's leg got worse. A Behavior Note, dated 05/06/2024, documented the resident kept yelling and screaming. 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. The clinical record for Resident #305 lacked documentation of pedal pulses assessed after 04/30/2024. On 06/11/2024 at 10:04 AM, the Unit Manager (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 verbalized the UM instructed the nurse to send the resident to the hospital if the resident experienced increased pain or further discoloration of the extremity. The UM verbalized the facility should have sent the resident to the hospital earlier and there was a delay in the care provided to the resident. The UM confirmed the only documented pedal pulse was on 04/30/2024, and pedal pulses should have been monitored at least daily for a suspected DVT. On 06/11/2024 at 10:46 AM, the Director of Nursing (DON) verbalized the resident had an order for an ultrasound on 04/30/2024, and the resident did not receive the ultrasound because the facility's contracted ultrasound provider did not have an ultrasound technician. The DON verbalized the resident should have been sent to the hospital for any changes in condition if the facility could not manage the issue. The DON verbalized continued assessment of the resident would have included assessing for pain and the perfusion to both lower extremities. The DON confirmed the assessment should have included checking pulses. The DON verbalized the resident should have been sent to the hospital when the skin checks on 05/01/2024, documented the resident had cold and clammy skin with bluish discoloration. The 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 the Physician would expect pedal pulses to be assessed when a resident had a suspected DVT, and an ordered ultrasound was delayed. 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. The Mayo Clinic document titled Deep vein thrombosis (DVT), dated 06/11/2022, documented leg swelling, leg pain, and change in skin color as possible symptoms of a DVT. The facility policy titled Licensed Nurses, Standard of Care, dated 07/2023, documented all Licensed Nurses would be expected to provide services including assessments, orders (receiving and transcribing), resident safety, cardiovascular conditions, and emergency and first aid. Licensed Nurses would perform an evaluation of diseases and conditions of the resident. Licensed Nurses would perform an evaluation of other pertinent information about the resident affecting the services the facility must provide. The facility policy titled, Resident Examination and Assessment, adopted 02/01/2019, documented the physical exam included assessing peripheral pulses (brachial, radial, femoral, popliteal, and dorsalis pedis). The Physician would be notified of any abnormalities. Complaint #NV00071241 Cross reference with tags F580 and F600 49557 Resident #455 Resident #455 was admitted to the facility on [DATE], with diagnoses including end stage heart failure and anemia, unspecified. A physician's order dated 05/24/2024, documented admit to Gentiva hospice, diagnosis heart failure with reduced ejection fraction. Resident #455's care plan documented the following: - Altered cardiovascular status related to permanent atrial fibrillation, congestive heart failure, pulmonary hypertension, hyperlipidemia and hypertension. The date initiated was 06/05/2024. Interventions included to administer medications as ordered. The date initiated was 06/05/2024. -Potential for fluid and/or electrolyte imbalance related to diuretic use. The date initiated was 06/05/2024. Interventions included medications as ordered. The date initiated was 06/05/20204. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/12/2024 at 9:42 AM, the Licensed Practical Nurse (LPN) assigned to Resident #455 explained staff knew a resident's hospice plan of care (POC) by reviewing the resident's hospice binder and/or by speaking directly with hospice staff when hospice staff came to see the resident. The LPN explained changes in condition, new medication orders, and any other concerns with the resident were communicated in the resident's hospice binder. The LPN located Resident #455's hospice binder and confirmed the binder lacked a POC, orders, and communication between hospice and facility staff. The LPN denied hospice staff had communicated with the LPN regarding Resident #455. A scanned document in Resident #455's clinical record, dated 06/04/2024, documented a physician's order to start Potassium Chloride Extended Release (ER), 10 milliequivalents (meq) ER tablet, give one tablet by mouth daily. Reason: Hypokalemia. An Order Review History Report for Resident #455 lacked an order for Potassium Chloride ER. On 06/12/2024 at 11:57 AM, the Director of Nursing (DON) explained facility staff communicated with hospice staff through the resident's hospice binder. The hospice binder typically contained contact information for the hospice provider, physician orders, and a POC. The DON explained if a new order was received from hospice, the resident's nurse would notify the facility physician and if the physician agreed, the nurse would enter the order into the electronic medical record (EMR). The DON further explained if a new order was received on a weekday the nurse would also notify the Unit Manager (UM). The DON verbalized the expectation when a new order was received was the order would be entered into the EMR by the end of the shift. During the interview, the DON reviewed Resident #455's clinical record. The DON confirmed a physician order dated 06/04/2024, with instruction to start Potassium Chloride ER, was scanned into the documents section of the resident's record. The DON confirmed Resident #455's clinical record lacked documented evidence the order for Potassium Chloride ER was communicated to the facility's physician, the facility's physician agreed with the order, and the order was entered into the EMR so it would reflect on the Medication Administration Record (MAR) as needing to be administered. On 06/12/2024 at 12:18 PM, the DON contacted the facility physician via phone. The facility physician provided a telephone order to start Potassium Chloride ER per the faxed hospice order. The DON then entered the order into the EMR. The DON explained the facility did not have one designated hospice coordinator, each unit's manager was responsible for coordinating with hospice. On 06/12/2024 at 12:21 PM, the UM verbalized an order for Potassium Chloride ER was not in Resident #455's electronic orders and was not on the resident's MAR. The UM confirmed the Potassium Chloride ER had not been administered as ordered. The UM verbalized faxes from hospice typically came directly to the nurses' station so staff could review the faxes and enter any new orders in the EMR as appropriate. The UM verbalized the UM was not going to look in the resident's scanned documents after each hospice visit to determine if new orders had been received. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/12/2024 at 12:29 PM, the LPN verbalized a bubble pack containing the ordered Potassium Chloride ER for Resident #455 was located in the medication cart. The bubble pack did not have any missing doses. The DON explained when hospice delivered medications to the facility, hospice staff would communicate with the facility nurse. The facility nurse would check the medication and the medication receipt. The DON verbalized the nurse who received the Potassium Chloride ER and placed the medication in the medication cart should have noted there was not a current order on the resident's MAR and contacted the physician. The facility document titled Nursing Facility Hospice Services Agreement, effective 09/25/2019, documented services to be provided by the nursing facility included coordination of services and administration of prescribed therapies. The nursing facility designee was responsible for collaborating with hospice representatives and coordinating nursing facility staff participation in the hospice care planning process, obtaining hospice medication information specific to each resident, and hospice physician and attending physician orders specific to reach resident.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43310 Based on observation, clinical record review, interview, and document review the facility failed to ensure 2 of 33 sampled residents (Resident #37 and #143) were weighed per facility policy. Findings include: Resident #37 Resident #37 was admitted to the facility on [DATE], with diagnoses including type II diabetes mellitus, unspecified dementia, unspecified severity, with other behavioral disturbance, and adult failure to thrive. Resident #37's Weights and Vital Signs Summary (Weight) report, documented an initial weight of 232.0 pounds (lbs) on 02/01/2019. Resident #37's Weight Report documented weights from June 2023 through November 2023 as follows: -06/11/2023: 194.0 lbs. -07/09/2023: 196.0 lbs. -07/21/2023: 196.0 lbs. -09/29/2023: 198.5 lbs. -10/12/2023: 225.4 lbs. -11/27/2023: 222.1 lbs. Resident #37's Weight Report did not document a weight for August 2023. Resident #37's clinical record lacked documented evidence the resident was weighed between 11/28/2023 and 06/11/2024. Resident #37's Order Summary Report did not include an order related to weighing the resident. A Nutrition/Dietary note dated 10/15/2023, documented Resident #37's weight was 225 lbs, showing a questionable weight gain of 26 lbs in two weeks. Nursing was asked to re-weigh the resident. A Nutrition/Dietary note dated 11/28/2023, documented Resident #37's weight stable at 222 lbs and the resident had an undesirable weight gain of 23 lbs during the previous two months. A Nutrition/Dietary note dated 01/23/2024, documented Resident #37 was weighed on 11/27/2023, and weighed 222 lbs. No new weights were available for the evaluation. A Nutrition/Dietary note dated 04/23/2024, documented Resident #37 was weighed on 11/27/2023 and weighed 222 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/11/2024 at 3:06 PM, a Licensed Practical Nurse (LPN) verbalized when a resident needed to be weighed, orders to weigh the resident were placed in the resident's clinical record. The LPN confirmed Resident #37's clinical record did not include an order to weigh the resident and the resident was last weighed on 11/27/2023. On 06/12/2024 at 9:30 AM, a Registered Nurse (RN) explained most residents were weighed one time per month. Residents with special dietary needs or weight loss were usually weighed one time per week. The expectation was all weights would be entered into a resident's clinical record after the resident was weighed. On 06/12/2024 at 10:26 AM, a Registered Dietician (RD) verbalized the RD's process included weekly review of weight reports. The RD explained when a resident was weighed the weight was entered in to the residents clinical record. Once the weight was entered into the clinical record, it populated to the weekly Weight Reports reviewed by the RD. The RD confirmed Resident #37 had not been weighed in over six months and should have been weighed monthly per the facility policy. On 06/12/2024 at 1:43 PM, the Director of Nursing (DON) confirmed the resident had not been weighed for over 6 months and should have been weighed once a month per facility policy. It was important to ensure residents were weighed one time per month in order to assess for weight loss, weight gain, and to determine if there was a change in dietary needs, or medications. On 06/12/2024 at 1:48 PM, the DON confirmed Resident #37's clinical record lacked documented evidence of a reason the resident could not be weighed, including if the resident refused to be weighed. The facility policy titled Weight Assessment and Intervention, dated 02/01/2019, documented residents were weighed upon admission, the following day, and weekly for two weeks. If weight concerns were not identified, the resident was weighed one time per month thereafter. Any weight change of 5 percent (%) or more since the previous assessment required the resident to be re-weighed the following day for confirmation. The RD was notified immediately, in writing, when a weight change of 5% or more was verified. Verbal notifications were to be confirmed in writing. 43311 Resident #143 Resident #143 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including acute duodenal ulcer with hemorrhage, and age-related cognitive decline. A physician's order dated 04/06/2024, documented Resident #143 would have weekly weights for four weeks, if weights stable, then every month. A physician's order dated 04/11/2024, document Resident #143 would have a weight obtained and documented in the electronic health record every day shift, every Thursday, for 30 days. May use the Hoyer lift scale. A physician's order dated 04/20/2024, documented Resident #143 would have weekly weights for four weeks, if weights stable, then every month. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #143's Weights and Vital Signs Summary Report documented weights for April 2024 through May 2024 as follows: -04/08/2024: 200.0 lbs (hospital) -05/09/2024: 129.0 lbs (Chair Scale) A Nutrition/Dietary Progress Note dated 04/30/2024, documented Resident #143 did not have a new admission weight for the re-admission on 04/20/2024, the resident was re-evaluated using the hospital weight of 200.0 lbs. The dietician would follow up with an admission weight and begin weekly weights for close monitoring. A Weight Committee Progress Note dated 05/15/2024, documented Resident #143 was seen by the Weight Committee, a facility weight of 129 lbs. taken on 05/09/2024, and showed a drastic/questionable 71 lbs. weight loss in one month. Interventions included a prescription for an appetite stimulant and nutrition shakes added to lunch and dinner. Weekly weights recommended for close monitoring and to establish baseline weight. A Mini Nutritional assessment dated [DATE], documented Resident #143 scored a nine which categorized the resident as at risk of malnutrition. The assessment was scored as follows: -12-14 points: Normal nutritional status -8-11 points: At risk of malnutrition -0-7 points: Malnourished A care plan dated 04/20/2024, documented Resident #143 had a nutritional problem or potential nutritional problem related to gastrointestinal bleed, rheumatoid arthritis, obese, and variable intake. Interventions dated 4/14/2024-5/15/2024, were as follows: -monitor/document/report oral intake -monitor/record/report weights -provide and serve diet as ordered -Remeron as ordered -special food items with meals -supplements as ordered (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alta Skilled Nursing and Rehabilitation Center	555 Hammill Lane Reno, NV 89511

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan dated 04/16/2024, documented Resident #143 was at risk of malnutrition per dietician assessment with interventions to observe for poor appetite, weight loss, and notify Physician of any changes. On 06/10/2024 at 8:23 AM, Resident #143 explained the resident did not feel like eating most of the time and thought there was weight loss. On 06/11/2024 at 9:27 AM, Resident #143 could not recall the last time the facility had performed a weight measurement. On 06/11/2024 at 1:49 PM, the DON explained all residents were to be weighed upon admission. The DON communicated Resident #143 should have been weighed weekly for four weeks and then monthly if the weight was stable. The DON confirmed there was only one weight in the resident's clinical record since admission and there should have been at least four weights for the weekly weights. The DON verbalized the expectation of the RD to ask for a re-weigh and not use the previous facility's weight as a baseline weight. The DON verbalized the expectation of nursing staff to take weekly weights as ordered. On 06/11/2024 at 2:39 PM, the RD confirmed Resident #143 should have been weighed upon admission and weekly for four weeks thereafter. The RD was aware of the documented weight loss of 71 lbs and had used the acute care hospital's weight of 200 lbs for a baseline weight rather than an actual physical weight performed by the facility. The RD confirmed the RD had asked the facility staff for weekly weights, but it was not done and only had the acute hospital's weight to use as a baseline weight. The RD confirmed the RD did not follow up on the weight monitoring. On 06/11/2024 at 2:42 PM, the RD confirmed Resident #143's clinical record had a weight measurement of 129 lbs. taken by the facility on 05/09/2024, indicating a 35.5% weight loss since 04/08/2024. The RD confirmed a discussion with the provider at the weight meeting on 05/15/2024, and weekly weights were to be performed to monitor the resident's weight loss of 35.5%. The RD confirmed weekly weights had not occurred as ordered or recommended. The facility policy titled, Weight Assessment and Intervention, dated 02/01/2019, documented the multidisciplinary team would strive to prevent, monitor, and intervene for undesirable weight loss for residents. The nursing staff would measure resident weights on admission, the next day, and weekly for two weeks thereafter. Any weight change of 5% or more since the last weight assessment would be taken the next day for confirmation. The Dietician would review the unit Weight Record by the 15th of the month to follow individual weight trends over time. Negative trends would be evaluated by the treatment team whether or not the criteria for significant weight change had been met. The threshold for significant unplanned and undesired weight loss would be based on the following: in 1 month-5% weight loss was significant; greater than 5% was severe.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 46301 Based on interview and personnel record review, the facility failed to ensure a Certified Nursing Assistant (CNA) had an annual performance evaluation completed timely for 1 of 2 CNAs employed greater than one year, sampled for personnel record review (Employee #8). Findings include: On 06/11/2024 at 10:55 AM, the Human Resources Manager and Regional Human Resources participated in an interview to confirm the accuracy of the Personnel Records Checklist completed by the facility for 20 employees. Employee #8 Employee #8 was hired as a CNA with a start date of 05/18/2022. The CNA's last performance evaluation was documented as completed on 07/11/2023. On 06/11/2024 at 1:53 PM, the Human Resources Manager provided Employee #8's date of last performance evaluation. The Human Resources Manager and Regional Human Resource were unable to provide evidence the CNA had an annual performance evaluation completed by 05/18/2023. The Human Resources Manager and Regional Human Resource confirmed the CNA annual performance evaluation was completed late. The facility policy titled Annual Review Process for Supportive Employees, undated, documented an annual review was to be performed on CNAs annually from the date of employment.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34524 Based on observation, interview, clinical record review, and document review the facility failed to ensure ordered medications were available and administered for 1 of 33 sampled residents (Resident #18). Findings include: Resident #18 Resident #18 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including other chronic pancreatitis, chronic pain, and other muscle spasms. On 06/10/2024 at 3:04 PM, Resident #18 verbalized they were out of medication for their muscle spasms and pancreatitis sometime last month. The resident explained they have chronic pain and not having the medication for their muscle spasms made their pain worse. A physician order dated 12/09/2022, documented Cyclobenzaprine HCl, 5 milligram tablet, give one tablet by mouth every six hours for muscle spasm. A physician order dated 12/09/2022, documented Creon Capsule Delayed Release Particles, 12000-38000 unit. Give one capsule by mouth with meals related to other chronic pancreatitis. On 06/12/2024 at 1:56 PM, a Registered Nurse (RN) verbalized Resident #18 received Creon Capsule Delayed Release Particles for chronic pancreatitis and Cyclobenzaprine for muscle spasms. The RN reviewed Resident #18's Medication Administration Record (MAR) for May 2024 and confirmed Resident #18 had missed administrations of Creon and Cyclobenzaprine in May 2024. The RN explained the resident did not receive the medications on the following days: Cyclobenzaprine; 05/19/2024 at 8:00 AM 05/19/2024 at 2:00 PM 05/20/2024 at 8:00 AM Creon; 05/26/2024 at 6:59 AM 05/27/2024 at 7:30 AM 05/27/2024 at 12:00 PM (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/27/2024 at 5:00 PM 05/28/2024 at 7:30 AM 05/28/2024 at 12:00 PM 05/28/2024 at 5:00 PM The RN explained the resident ran out of the medications and the medications had to be reordered from the pharmacy. The process was to order medications from the pharmacy two to three days before the medication ran out. The RN was unable to provide evidence the medications had been reordered prior to the medication running out. An Orders-Administration Note dated 05/19/2024 at 8:55 AM, documented Cyclobenzaprine HCl, 5 mg tablet, give one tablet by mouth every six hours for muscle spasm. Medication needed refill, medication on order. An Orders-Administration Note dated 05/19/2024 at 1:07 PM, documented Cyclobenzaprine HCl, 5 mg tablet, give one tablet by mouth every six hours for muscle spasm. Medication needed refill, medication on order. An Orders-Administration Note dated 05/20/2024 at 7:19 AM, documented Cyclobenzaprine HCl, 5 mg tablet, give one tablet by mouth every six hours for muscle spasm. On order. An Orders-Administration Note dated 05/26/2024 at 6:59 AM, documented Creon Capsule Delayed Release Particles, 12000-38000 unit. Give one capsule by mouth with meals related to other chronic pancreatitis. Medication needed refill. Ordered refill to pharmacy. An Orders-Administration Note dated 05/27/2024 at 8:08 AM, documented Creon Capsule Delayed Release Particles, 12000-38000 unit. Give one capsule by mouth with meals related to other chronic pancreatitis. Medication needed refill. Ordered refill to pharmacy. On order. An Orders-Administration Note dated 05/27/2024 at 11:56 AM, documented Creon Capsule Delayed Release Particles, 12000-38000 unit. Give one capsule by mouth with meals related to other chronic pancreatitis. Medication needed refill. Not available. An Orders-Administration Note dated 05/27/2024 at 4:58 PM, document Creon Capsule Delayed Release Particles, 12000-38000 unit. Give one capsule by mouth with meals related to other chronic pancreatitis. Medication needed refill. On order. An Orders-Administration Note dated 05/28/2024 at 7:16 AM, documented Creon Capsule Delayed Release Particles, 12000-38000 unit. Give one capsule by mouth with meals related to other chronic pancreatitis. Medication needed refill. On order. An Orders-Administration Note dated 05/28/2024 at 12:00 PM, documented Creon Capsule Delayed Release Particles, 12000-38000 unit. Give one capsule by mouth with meals related to other chronic pancreatitis. Medication needed refill. Not available. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Orders-Administration Note dated 05/28/2024 at 4:50 PM, documented Creon Capsule Delayed Release Particles, 12000-38000 unit. Give one capsule by mouth with meals related to other chronic pancreatitis. Medication needed refill. On order. On 06/12/2024 at 3:59 PM, the Director of Nursing (DON) verbalized the expectation was the medication to be reordered from the pharmacy within seven days, no less than three days, prior to the medication running out. The DON explained staff should not wait until the day before or the day of the medication running out to reorder from the pharmacy as the policy states the medication needed to be reordered three days prior to the medication running out. The DON confirmed the resident missed medication administrations of Cyclobenzaprine and Creon in May 2024. The DON confirmed there was not documentation the medication was reordered in the three day time frame required by policy. The facility policy titled, Medication and Treatment Orders, 02/01/2019, documented drugs and biologicals must be reordered from the issuing pharmacy not less than three days prior to the last dosage being administered to ensure refills were readily available.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 31739 Based on document review and interview, the facility failed to demonstrate effective administration by not ensuring ultrasounds were obtained timely as the facility's current contracted diagnostics company did not have an ultrasound technician (See Tag F600). Finding include: On 06/13/2024 at 1:41 PM, the Administrator verbalized having been unsure when first notified the contracted diagnostics company did not have an ultrasound technician to complete onsite visits but was possibly notified at the end of April 2024. The Administrator was unable to provide documented evidence the lack of an ultrasound technician was addressed, or direction or instruction provided to nursing staff. On 06/13/2024 at 1:57 PM, the Director of Nursing (DON), verbalized having been aware of the lack of an ultrasound technician and to send residents to the hospital for an ultrasound if needed, when the DON worked in the Rehabilitation Department, prior to becoming the DON. The DON verbalized not having been aware if nursing staff had been informed of the need to send residents to the hospital prior to becoming the DON. The facility policy titled, Quality Assurance and Performance Improve (QAPI) Program, adopted 02/01/2019, documented the committee would oversee the implementation of the QAPI Plan and the specifics of the QAPI Program and would identify and correct quality deficiencies.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43311 Based on interview, clinical record review, and document review, the facility failed to ensure a resident's medical record was complete for 2 of 33 sampled residents (Resident #143 and #205). Findings include: Resident #143 Resident #143 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including acute duodenal ulcer with hemorrhage and age-related cognitive decline. A physician's order dated 04/06/2024, documented Resident #143 would have weekly weights for four weeks, if weights stable, then every month. A physician's order dated 04/11/2024, document Resident #143 would have a weight obtained and documented in the electronic health record every day shift, every Thursday, for 30 days. May use the Hoyer lift scale. A physician's order dated 04/20/2024, documented Resident #143 would have weekly weights for four weeks, if weights stable, then every month. Resident #143's Weights and Vital Signs Summary Report documented weights for April 2024 and May 2024 as follows: -04/08/2024: 200 lbs -05/09/2024: 129 lbs Resident #143's clinical record lacked a documented reason the resident was not weighed on 04/18/2024, 04/25/2024, 05/02/2024, 05/16/2024, 05/23/2024, and 05/30/2024. On 06/11/2024 at 9:27 AM, Resident #143 could not recall the last time the facility had performed a weight measurement. On 06/11/2024 at 1:49 PM, the Director of Nursing (DON) explained all residents were to be weighed upon admission. The DON communicated Resident #143 should have been weighed weekly for four weeks and then monthly if the weight was stable. The DON confirmed there was only one weight in the resident's clinical record and there should have been at least four weights. The DON verbalized the expectation of the Registered Dietician (RD) to ask for a re-weigh and not use the previous facility's weight as a baseline weight. The DON explained the expectation of nursing to follow the physician's orders as written. On 06/11/2024 at 2:42 PM, the RD confirmed weekly weights had not occurred and the clinical record lacked weight measurements as ordered. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Weight Assessment and Intervention, adopted 02/01/2019, documented the nursing staff would measure resident weights on admission, the next day, and weekly for two weeks thereafter. Weights would be recorded in each unit's Weight Record or notebook and in the resident's medical record. Cross reference with tag F 692 31739 Resident #205 Resident #205 was admitted to the facility on [DATE], with diagnoses including unspecified protein-calorie malnutrition, dysphagia following cerebral infarction, dysphagia, unspecified, pneumonitis due to inhalation of food and vomit. A physician's order dated 05/30/2024, documented gastrostomy tube (G-Tube), flush before, after and between medication administration and after bolus. Every shift. Flush with 30 cubic centimeters (cc) water (H20) before medication administration. Flush with 10 cc H20 between each medication administration. Resident #205's Treatment Administration Record (TAR) dated 06/02/2024, lacked documented evidence the G-Tube was flushed per the physician order. A physician's order dated 06/07/2024, documented G-Tube, flush 65 milliliters (ml) H20 every hour, via pump, every shift. Resident #205's Medication Administration Record (MAR) dated 06/08/2024, lacked documented evidence the G-Tube was flushed per the physician order. On 06/13/2024 at 10:41 AM, the DON confirmed Resident #205's TAR dated 06/02/2024, and MAR dated 06/08/2024, lacked documented evidence the G-Tube was flushed per the physician orders. The facility policy titled, Charting and Documentation, adopted 02/01/2019, documented medications administered and treatments performed would be documented in the resident's clinical record.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 31739 Based on document review and interview, the facility's Quality Assessment and Performance Improvement (QAPI) committee failed to identify the facility's contracted diagnostics company lacked an ultrasound technician resulting in a delay for a resident with a physician's order for an ultrasound (See Tag F600). Findings include: On 06/13/2024 at 1:41 PM, the Administrator verbalized having been unsure when first notified the contracted diagnostics company did not have an ultrasound technician to complete onsite visits but was possibly notified at the end of April 2024. The Administrator was unable to provide documented evidence the lack of an ultrasound technician was addressed, or direction or instruction provided to nursing staff. On 06/13/2024 at 1:57 PM, the Director of Nursing (DON), verbalized having been aware of the lack of an ultrasound technician and to send residents to the hospital for an ultrasound if needed, when the DON worked in the Rehabilitation Department, prior to becoming the DON. The DON verbalized not having been aware if nursing staff had been informed of the need to send residents to the hospital prior to becoming the DON. The facility policy titled, Quality Assurance and Performance Improve (QAPI) Program, adopted 02/01/2019, documented the committee would oversee the implementation of the QAPI Plan and the specifics of the QAPI Program and would identify and correct quality deficiencies.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on observation, interview, clinical record review, and document review the facility failed to ensure Enhanced Barrier Precautions (EBP) were implemented when providing care to a resident's jejunostomy tube (J-tube) for 1 of 33 sampled residents (Resident #109). Findings include: Resident #109 Resident #109 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of other artificial openings of gastrointestinal tract status. On 06/10/2024 at 10:00 AM, a sign outside Resident #109's room indicated the resident was on EBP. The sign instructed staff to wear a gown and gloves while providing high-contact care. On 06/10/2024 at 10:05 AM, Resident #109 was receiving tube feeding via an enteral feeding pump. A Licensed Practical Nurse (LPN) entered Resident #109's room, stopped the pump, and disconnected the tube feeding from the resident's J-tube. The LPN was not wearing a gown or gloves. On 06/10/2024 at 10:07 AM, while in the hallway outside the resident's room, the LPN explained the sign outside Resident #109's room indicated the resident was on EBP. The LPN confirmed the LPN was not wearing a gown or gloves when the LPN disconnected the resident's tube feeding and verbalized a gown and gloves should be worn when providing care to Resident #109's J-tube. The LPN explained EBP helped to prevent infections. Resident #109's care plan documented a focus of EBP related to the presence and care of a J-tube. The date initiated was 01/10/2024. Interventions included EBP per facility policy. The date initiated was 01/10/2024. On 06/12/2024 at 11:53 AM, the Director of Nursing (DON) explained a gown and gloves were required when providing care to a resident's feeding tube as residents with feeding tubes were on EBP. The reason for EBP was to help prevent the introduction of bacteria, which could cause infection, to residents with indwelling medical devices. The facility policy titled Infection Prevention and Control Program (IPCP), undated, documented EBP served as an infection control intervention to lessen the transmission of multidrug-resistant organisms (MDRO). EBP applied to residents with any indwelling medical device. Staff were to wear a gown and gloves when performing high-contact resident care activities which included indwelling medical device care.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on clinical record review, interview, and document review, the facility failed to ensure residents were screened for eligibility to receive a pneumococcal vaccination, education regarding the vaccine was provided to the resident and/or the Resident Representative, and the vaccine was offered and either administered or declined for 28 of 163 residents in the facility (Resident #410, #158, #255, #163, #106, #112, #85, #17, #27, #124, #9, #83, #50, #156, #47, #155, #61, #8, #117, #81, #161, #310, #115, #55, #18, #122, #46 and #104). Findings include: Resident #410 Resident #410 was admitted to the facility on [DATE], with diagnoses including moderate protein-calorie malnutrition and alcohol abuse with withdrawal, unspecified. Resident #158 Resident #158 was admitted to the facility on [DATE], with diagnoses including saddle embolus of pulmonary artery without acute cor pulmonale and tobacco use. Resident #255 Resident #255 was admitted to the facility on [DATE], with diagnoses including unspecified symptoms and signs involving cognitive functions following cerebral infarction and alcohol abuse, uncomplicated. Resident #163 Resident #163 was admitted to the facility on [DATE], with diagnoses including unspecified sequelae of cerebral infarction and tobacco use. Resident #106 Resident #106 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including epilepsy, unspecified, intractable, with status epilepticus and type two diabetes mellitus with hypoglycemia with coma. Resident #112 Resident #112 was admitted to the facility on [DATE], with diagnoses including spinal stenosis, cervical region, and tobacco use. Resident #85 (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #85 was admitted to the facility on [DATE], with diagnoses including nontraumatic intracerebral hemorrhage in hemisphere, subcortical and alcohol abuse, uncomplicated. Resident #17 Resident #17 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary disease, unspecified and type two diabetes mellitus without complications. Resident #27 Resident #27 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including bipolar disorder, unspecified and alcohol abuse, uncomplicated. Resident #124 Resident #124 was admitted to the facility on [DATE], with diagnoses including encounter for surgical aftercare following surgery on the digestive system, nicotine dependence, unspecified, uncomplicated and tobacco use. Resident #9 Resident #9 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic respiratory failure with hypoxia and type two diabetes mellitus with diabetic neuropathy, unspecified. Resident #83 Resident #83 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of unspecified sequelae of cerebral infarction. Resident #50 Resident #50 was admitted to the facility on [DATE], with diagnoses including cardiomyopathy, unspecified and tobacco use. Resident #156 Resident #156 was admitted to the facility on [DATE], with diagnoses including encounter for surgical aftercare following surgery on the digestive system and alcohol use, unspecified with withdrawal delirium. Resident #47 Resident #47 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including epileptic seizures related to external causes, not intractable, without status epilepticus and thyrotoxicosis, unspecified without thyrotoxic crisis or storm. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #155 Resident #155 was admitted to the facility on [DATE], with diagnoses including encounter for other orthopedic aftercare and atherosclerotic heart disease of native coronary artery without angina pectoris. Resident #61 Resident #61 was admitted to the facility on [DATE], with diagnoses including polyneuropathy, unspecified and type two diabetes mellitus without complications. Resident #8 Resident #8 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unspecified sequelae of cerebral infarction and alcoholic cirrhosis of liver without ascites. Resident #117 Resident #117 was admitted to the facility on [DATE], with diagnoses including acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure and chronic kidney disease, stage three unspecified. Resident #81 Resident #81 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including quadriplegia, unspecified and chronic respiratory failure with hypoxia. Resident #161 Resident #161 was admitted to the facility on [DATE], with diagnoses including encounter for other orthopedic aftercare and type two diabetes mellitus without complications. Resident #310 Resident #310 was admitted to the facility on [DATE], with diagnoses including parkinsonism, unspecified and chronic systolic (congestive) heart failure. Resident #115 Resident #115 was admitted to the facility on [DATE], with diagnoses including Wernicke's encephalopathy and type two diabetes mellitus with other circulatory complications. Resident #55 Resident #55 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unspecified sequelae of cerebral infarction and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. (continued on next page)

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	06/13/2024

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #18 Resident #18 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary disease, unspecified and type two diabetes mellitus with diabetic neuropathy, unspecified. Resident #122 Resident #122 was admitted to the facility on [DATE], with diagnoses including traumatic hemorrhage of cerebrum, unspecified, without loss of consciousness, subsequent encounter and alcohol dependence, uncomplicated. Resident #46 Resident #46 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unspecified sequelae of cerebral infarction, chronic respiratory failure with hypoxia and atherosclerotic heart disease of native coronary artery without angina pectoris. Resident #104 Resident #104 was admitted to the facility on [DATE], with diagnoses including type two diabetes mellitus without complications and end stage renal disease. Resident #104's clinical record included a Pneumococcal Vaccine Permission Statement dated 05/15/2024. The Pneumococcal Vaccine Permission Statement documented Resident #104 was not eligible to receive a pneumococcal vaccine as the resident was less than [AGE] years old. On 06/13/2024 at 11:44 AM, during an interview with the Infection Control Preventionist (ICP) and the [NAME] President of Clinical Services (VPCS), the ICP explained residents were screened for eligibility to receive a pneumococcal vaccine upon admission and annually using a flowchart. The ICP verbalized residents aged 65 and older were eligible for the vaccine. The ICP confirmed the flowchart in the facility's policy titled Pneumococcal Vaccine was utilized to screen residents for eligibility to receive the pneumococcal vaccine. The ICP confirmed the first question on the flowchart asked if the resident was [AGE] years or older and confirmed if the resident was not [AGE] years or older the resident was determined to not be eligible for the pneumococcal vaccine. When asked if certain conditions made a resident under the age of 65 eligible for the pneumococcal vaccine, the ICP did not respond. The VPCS then verbalized there were conditions which made a resident eligible for the vaccine when the resident was under the age of 65 such as diabetes and if the resident was immunocompromised. The VPCS confirmed the facility followed the Centers for Disease Control and Prevention (CDC) guidelines for determining vaccine eligibility. On 06/13/2024 at 11:53 AM, the ICP and the VPCS reviewed Resident #104's clinical record and confirmed the resident had type two diabetes mellitus which made the resident eligible for the pneumococcal vaccine. The ICP and the VPCS confirmed Resident #104 should have been offered the pneumococcal vaccine. (continued on next page)

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The ICP and VPCS confirmed residents #410, #158, #255, #163, #106. #112, #85, #17, #27, #124, #9, #83, #50, #156, #47, #155, #61, #8, #117, #81, #161, #310, #115, #55, #18, #122, #46 and #104 were determined to be not eligible for the pneumococcal vaccine based on age alone and the residents were not screened for eligibility based on any additional criteria. The facility policy titled Pneumococcal Vaccine, adopted by the facility on 02/01/2019, documented all residents were to be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Prior to or upon admission, residents would be assessed for eligibility to receive the pneumococcal vaccine series. The facility document titled Let's Talk Vaccines - CDC Vaccine Information Statements, updated 01/2024, documented pneumococcal polysaccharide vaccine (PPSV23) was recommended for anyone two years old or older with certain medical conditions. Pneumococcal conjugate vaccine (PCV) was recommended for adults 19 through [AGE] years old with certain medical conditions or other risk factors. The CDC document titled Pneumococcal Vaccination: Summary of Who and When to Vaccinate, last reviewed 09/22/2023, documented adults 19 through [AGE] years old with certain risk conditions were eligible to receive a pneumococcal vaccine.