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	05/15/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and document review, the facility failed to ensure a resident's Care Plan was integrated with the hospice plan of care and included a care plan addressing the resident's wound care for 1 of 32 sampled residents (Resident #19). This deficient practice had the potential to result in staff caring for the resident not being aware of the care to be provided to the resident by hospice staff versus care to be provided by facility staff leading to a potential decline in the quality of care the resident received in the facility and the resident not receiving wound care as ordered. Findings include: Resident #19 Resident #19 was admitted to the facility on [DATE], with diagnoses including encounter for palliative care and abnormal findings on diagnostic imaging of other specified body structures. On 05/12/2025 at 2:12 PM, the representative for Resident #19 verbalized the resident had a large mass on the resident's breast and the mass had begun tunnelling and now required wound care. The representative verbalized the resident was on hospice and hospice was providing the resident's wound care. A Hospice Visit Note, dated 05/05/2025, documented the dressing was removed from the lateral wound bed. The wound was actively bleeding. Topical treatment was applied per wound care protocol. On 05/14/2025 at 3:48 PM, the Registered Nurse (RN) for Resident #19 verbalized the resident did not have an order for wound care or a care plan addressing wound care but the resident was on hospice and the hospice agency was managing the resident's wound. On 05/15/2025 at 8:46 AM, the Unit Manager confirmed the resident did not have a care plan for the wound care provided by the hospice agency. On 05/15/2025 at 8:58 AM, the Director of Nursing verbalized a resident's wound care should have been ordered in the facility's electronic health record and the Care Plan should have been integrated with the hospice plan of care and include the wound care provided by the hospice agency. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Care Plans, Comprehensive Person-Centered, adopted 02/01/2019, documented a comprehensive, person-centered care plan would be developed and implemented for each resident. The comprehensive, person-centered care plan would incorporate identified problem areas, reflect treatment goals, identify the professional services responsible for each element of care, and reflect currently recognized standards of practice for problem areas and conditions. Cross reference with tags F684 and F849

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** Based on observation, interview, clinical record review, and document review, the facility failed to ensure resident's care plans were updated to include a resident's need for an appointment with a neurologist due to an increase in the resident's tremors from Parkinson's disease and a resident's continued habit of smoking and storing smoking paraphernalia in the resident's room for 2 of 32 residents (Resident #25 and #13). This deficient practice had the potential to result in staff not being aware of a resident's need for an appointment with a specialist physician to address a resident's medical needs and staff not being aware of the need to continue to assess a resident for safety concerns related to the resident smoking independently and keeping smoking paraphernalia in the resident's room. Findings include: Resident #25 Resident #25 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Parkinson's disease without dyskinesia, without mention of fluctuations and multiple sclerosis. On 05/12/2025 at 1:16 PM, the representative for Resident #25 verbalized the resident needed to see a neurologist to adjust the resident's medications. The representative verbalized the representative had requested an appointment for the resident at each care conference the representative had attended over the last several months. The representative verbalized the staff at the care conference agreed with the need for the resident to see a neurologist, but the facility had not yet made the resident an appointment. A Physician's Order for Resident #25, dated 03/20/2025, documented appointment request: needs neurology appointment for noted increase in tremors related to a diagnosis of Parkinson's disease. The Care Plan for Resident #25 did not include a care plan revision regarding the resident's symptoms of increased tremors or the need to schedule an appointment with a neurologist. On 05/15/2025 at 11:37 AM, the Director of Nursing (DON) and the Unit Manager explained the facility had utilized verbal communication regarding the status of the resident's neurology appointment and confirmed the resident did not yet have an appointment scheduled and the appointment request had not yet been sent to all neurologist offices in the area. Resident #13 Resident #13 was admitted to the facility on [DATE], with diagnoses including tobacco use and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. On 05/12/2025 at 12:03 PM, Resident #13 returned to the resident's room and smelled strongly of tobacco smoke. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The resident confirmed the resident had returned from outside of the facility and the resident was allowed to go outside of the facility to smoke. On 05/13/2025 at 7:35 AM and on 05/14/2025 at 7:05 AM, Resident #13 was observed in the resident's wheelchair smoking in a parking lot adjacent to the facility's parking lot. On 05/14/2025 at 11:23 AM, the Certified Nursing Assistant (CNA) for Resident #13 verbalized the CNA would assist Resident #13 to get out of bed and into the resident's wheelchair to go outside to smoke but the CNA did not know where the resident kept the resident's cigarettes and smoking paraphernalia. On 05/14/2025 at 11:24 AM, the Licensed Practical Nurse (LPN) for Resident #13 verbalized the LPN did not know where the resident's cigarettes were stored. On 05/14/2025 at 11:34 AM, Resident #13 verbalized the resident kept the resident's cigarettes and lighter in the resident's bed side table when not on the resident's person. The Care Plan for Resident #13 documented the resident had a history of Nicotine use and was last revised on 07/23/2024. The care plan did not address the resident's continued use of nicotine or a plan to ensure the safe storage and use of the resident's smoking paraphernalia. On 05/14/2025 at 1:56 PM, the DON verbalized the facility did not care plan interventions to ensure a resident was safe when smoking off facility property but would only care plan to remind the resident of the facility's no smoking policy. The facility policy titled, Care Plans, Comprehensive Person-Centered, adopted 02/01/2019, documented the Care Plan would describe the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and incorporate the resident's identified problem areas and risk factors associated with identified problems. Cross reference with tags F658 and F684

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and document review, the facility failed to ensure a resident's physician order for a neurologist referral due to an increase in the resident's tremors from Parkinson's disease was acted on in a timely manner and monitored for completeness by clinical leadership for 1 of 32 sampled residents (Resident #25). This deficient practice had the potential to result in a resident's symptoms not being managed timely and causing a resident unnecessary discomfort and decreased quality of life from a delay in care. Findings include: Resident #25 Resident #25 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Parkinson's disease without dyskinesia, without mention of fluctuations and multiple sclerosis. On 05/12/2025 at 1:16 PM, the representative for Resident #25 verbalized the resident needed to see a neurologist to adjust the resident's medications. The representative verbalized the representative had requested an appointment for the resident at each care conference the representative had attended over the last several months. The representative verbalized the staff at the care conference agreed with the need for the resident to see a neurologist, but the facility had not yet made the resident an appointment. A Care Conference note, dated 02/21/2025, documented a request for neurology follow up. A Progress Note, dated 02/27/2025, documented the referral for neurology was rewritten. The neurologist Resident #25 used to see no longer took the resident's insurance. The referral would be faxed to multiple offices. A Physician's Order for Resident #25, dated 03/20/2025, documented appointment request: needs neurology appointment for noted increase in tremors related to a diagnosis of Parkinson's disease. The Care Plan for Resident #25 did not include a care plan revision regarding the resident's symptoms of increased tremors or the need to schedule an appointment with a neurologist. The following referrals were documented: - A referral sent to the resident's previous neurologist on 10/31/2024. The faxed response from the neurologist's office documented the office was not contracted with the resident's insurance plan. - A referral was again sent to the resident's previous neurologist on 02/25/2025. The faxed response from the neurologist's office documented the patient had not been seen at the office since 2021. The office was not contracted with the resident's health plan. The office could not see the patient. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/14/2025 at 4:14 PM, the Unit Manager (UM) verbalized the resident's representative had requested for the resident to see the resident's previous neurologist, but the resident's previous neurologist no longer accepted the resident's insurance. The UM verbalized Transportation Services was responsible for coordinating resident referrals and appointments. On 05/15/2025 at 11:11 AM, a Transportation Coordinator (TC) verbalized a referral had been sent to Resident #25's previous neurologist on 10/31/2024 and again on 02/25/2025. The TC confirmed the referral had not been sent to any other neurologists in the area. The TC explained the information to make a referral was communicated to the TC through a spreadsheet and the information on the spreadsheet was entered by the nursing staff. The TC verbalized the information for Resident #25's referral documented to send the referral to a specific neurologist's office and the referrals were sent to the same neurologist's office in both October and February and had not been sent to other neurologist offices. On 05/15/2025 at 11:37 AM, the Director of Nursing (DON) and the UM explained the facility had utilized verbal communication regarding the status of the resident's neurology appointment and confirmed the resident did not yet have an appointment scheduled and the appointment request had not yet been sent to all neurologist offices in the area. The DON explained the TCs were not part of the care conferences, and the DON would ask the TCs about the resident's appointment status and had been told the TCs were unable to find an office to accept the resident's insurance. The DON confirmed the DON did not review the TC's spreadsheet to ensure referrals were sent appropriately and the physician order for the referral was not for a specific neurology office. The facility policy titled, Referrals, adopted 02/01/2019, documented the facility would coordinate resident referrals. Facility staff would help arrange transportation to appointments. Referrals for medical services would be based on physician evaluation of resident need and a related physician order. Cross reference with tags F657 and F684

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and document review, the facility failed to ensure a resident's symptoms of increased tremors was managed timely per the physician's order to make a referral to a neurologist and a resident's wound was monitored by the facility and the facility had an order and care plan to address the facility's role in providing care for the resident's wound for 2 of 32 sampled residents (Resident #25 and #19). This deficient practice had the potential to result in a resident experiencing increased physical discomfort due to not receiving a timely appointment with a specialist physician as ordered and a resident's wound not receiving necessary care and potentially worsening without the facility's knowledge. Findings include: Resident #25 Resident #25 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Parkinson's disease without dyskinesia, without mention of fluctuations and multiple sclerosis. On 05/12/2025 at 1:16 PM, the representative for Resident #25 verbalized the resident needed to see a neurologist to adjust the resident's medications because the resident was having increased tremors. The representative verbalized the representative had requested an appointment for the resident at each care conference the representative had attended over the last several months. The representative verbalized the staff at the care conference agreed with the need for the resident to see a neurologist, but the facility had not yet made the resident an appointment. A Care Conference note, dated 02/21/2025, documented a request for neurology follow up. A Progress Note, dated 02/27/2025, documented the referral for neurology was rewritten. The provider Resident #25 used to see no longer took the resident's insurance. The referral would be faxed to multiple offices. A Physician's Order for Resident #25, dated 03/20/2025, documented appointment request: needs neurology appointment for noted increase in tremors related to a diagnosis of Parkinson's disease. The Care Plan for Resident #25 did not include a care plan revision regarding the resident's symptoms of increased tremors or the need to schedule an appointment with a neurologist. The following referrals were documented: - A referral sent to the resident's previous neurologist on 10/31/2024. The faxed response from the neurologist's office documented the office was not contracted with the resident's insurance plan. - A referral was again sent to the resident's previous neurologist on 02/25/2025. The faxed response from the neurologist's office documented the patient had not been seen at the office since 2021. The office was not contracted with the resident's health plan. The office could not see the patient. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 05/14/2025 at 4:14 PM, the Unit Manager (UM) verbalized the resident's representative had requested for the resident to see the resident's previous neurologist, but the resident's previous neurologist no longer accepted the resident's insurance. The UM verbalized Transportation Services was responsible for coordinating resident referrals and appointments. On 05/15/2025 at 11:11 AM, a Transportation Coordinator (TC) verbalized a referral had been sent to Resident #25's previous neurologist on 10/31/2024 and again on 02/25/2025. The TC confirmed the referral had not been sent to any other neurologists in the area. The TC explained the information to make a referral is communicated to the TC through a spreadsheet and the information on the spreadsheet is entered by the nursing staff. The TC verbalized the information for Resident #25's referral documented to send the referral to a specific neurologist's office and the referrals were sent to the same neurologist's office in both October and February and had not been sent to other neurologist offices. On 05/15/2025 at 11:37 AM, the Director of Nursing (DON) and the UM explained the facility had utilized verbal communication regarding the status of the resident's neurology appointment and confirmed the resident did not yet have an appointment scheduled and the appointment request had not yet been sent to all neurologist offices in the area. The DON explained the TCs were not part of the care conferences, and the DON would ask the TCs about the resident's appointment status and had been told the TCs were unable to find an office to accept the resident's insurance. The DON confirmed the DON did not review the TC's spreadsheet to ensure referrals were sent appropriately and the physician order for the referral was not for a specific neurology office. The facility policy titled, Referrals, adopted 02/01/2019, documented the facility would coordinate resident referrals. Facility staff would help arrange transportation to appointments. Referrals for medical services would be based on physician evaluation of resident need and a related physician order. Resident #19 Resident #19 was admitted to the facility on [DATE], with diagnoses including encounter for palliative care and abnormal findings on diagnostic imaging of other specified body structures. On 05/12/2025 at 2:12 PM, the representative for Resident #19 verbalized the resident had a large mass on the resident's breast and the mass had begun tunnelling and now required wound care. The representative verbalized the resident was on hospice and hospice was providing the resident's wound care. A Hospice Certification, dated 03/27/2025, documented the resident had a non-healing right breast wound with underlying mass. A Hospice Visit Note, dated 05/05/2025, documented the dressing was removed from the lateral wound bed. The wound was actively bleeding. Topical treatment was applied per wound care protocol. On 05/14/2025 at 3:48 PM, the Registered Nurse (RN) for Resident #19 verbalized the resident did not have an order for wound care or a care plan addressing wound care but the resident was on hospice and the hospice agency was managing the resident's wound. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 05/15/2025 at 8:46 AM, the UM confirmed the resident did not have a care plan for the wound care provided by the hospice agency. On 05/15/2025 at 8:58 AM, the DON verbalized a resident's wound care should have been ordered in the facility's electronic health record and the Care Plan should have been integrated with the hospice plan of care and include the wound care to be provided by the hospice agency and the responsibilities of facility staff in managing the wound. The facility policy titled Skin and Wound Management, revised 03/03/2025, documented the facility would develop and use care planning protocols and interventions would be implemented based on the resident's assessment. All wound care protcols would be reviewed by the medical director. Cross reference with tags F656, F657, F658, and F849.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and document review, the facility failed to ensure 1) a resident determined to be at risk for pressure injury did not develop a pressure injury, and 2) a resident received wound care per physician orders and the facility policy for 1 of 32 sampled residents (Resident #3). The deficient practices had the potential to place the resident at risk for delayed wound healing and infection. Findings include: Resident #3 Resident #3 was admitted to the facility on [DATE], with diagnoses including adult failure to thrive, long term use of anticoagulants, unspecified sequelae of cerebral infarction, and chronic kidney disease, stage III, unspecified. The admission Braden Scale for Predicting Pressure Score Risk assessment dated [DATE], documented Resident #3 did not have a skin impairment and was at risk for pressure-related skin impairment due to shear friction and bed confinement. A care plan with an initiation date of 01/21/2025, documented Resident #3 was at risk for skin pressure injury formation. Interventions included keeping the resident as clean and dry as possible, provide peri care after incontinent episodes, and a Licensed Nurse to perform weekly skin checks. A Skin/Wound Progress Note dated 02/25/2025, documented Resident #3 was evaluated by the Wound Care Nurse to have a Stage III pressure injury (a skin injury developed from pressure over an area or bony prominence which involves full thickness skin tissue loss) to the coccyx area measuring 1.2 centimeters (cm) in length by 1.0 cm in width and was unable to determine the depth. The coccyx pressure injury was initially observed on 02/24/2025, after a post shower skin check. A care plan with an initiation date of 02/25/2025, documented Resident #3 had a coccyx pressure injury related to decreased mobility. Interventions included administer treatments as ordered and monitor for effectiveness. Resident #3's physician order dated 02/25/2025, and discontinued on 04/17/2025, documented to cleanse coccyx pressure injury with normal saline, pat dry with gauze, apply skin prep to peri wound, allow to air dry and cover with silicone bordered dressing every day shift and as needed (PRN) every 24 hours for soiled/dislodgement. Resident #3's physician order dated 04/18/2025, documented to cleanse coccyx pressure injury with normal saline, pat dry with gauze, apply medi-honey, followed by zinc oxide and leave open to air every shift and PRN every 24 hours for soiled/dislodgement. A Wound Care Treatment Administration Record (TAR) dated April 2025, lacked documented evidence wound care was provided to the coccyx wound on the following dates and shifts: 04/17/2025: all shifts blank (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/18/2025: evening shift blank 04/20/2025: all shifts blank 04/21/2025: evening shift blank 04/22/2025: evening shift blank 04/23/2025: all shifts blank 04/24/2025: evening shift blank 04/26/2025: day and evening shifts blank 04/27/2025: all shifts blank 04/28/2025: evening shift blank 04/29/2025: evening shift blank 04/30/2025: evening and night shifts blank A Wound Care TAR dated May 2025, lacked documented evidence wound care was provided to the coccyx wound on the following dates and shifts: 05/01/2025: evening and night shifts blank 05/02/2025: evening and night shifts blank 05/03/2025: evening shift blank 05/04/2025: all shifts blank 05/05/2025: evening shift blank 05/06/2025: evening and night shift blank 05/07/2025: night shift blank 05/08/2025: evening shift blank 05/09/2025: evening shift blank 05/10/2025: evening shift blank 05/11/2025: all shifts blank 05/12/2025: evening shift blank (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/13/2025 at 4:16 PM, the Director of Nursing (DON) confirmed Resident #3's pressure injury was identified on 02/24/2025. The DON confirmed Resident #3's current wound care order and explained the order was not written correctly as the wound care would not occur each shift of each day. The DON confirmed Resident #3's Wound Care TAR was left blank on several dates in April and May of 2025, and the blanks indicated the wound care was not completed on those dates. The DON confirmed wound care was not provided as the physician had ordered and expected nursing to follow physician orders as written. On 05/14/2025 at 8:14 AM, the Wound Care Nurse confirmed Resident #3's current wound care orders for a facility acquired Stage III coccyx wound was first observed on 02/24/2025, after a shower skin check. Residents received a skin check on the assigned shower days and was performed by a Certified Nursing Assistant, who would then notify the nurse of any skin changes. The coccyx wound/pressure injury was not identified prior to 02/24/2025, when it was assessed as a Stage III. The Wound Care Nurse explained writing the wound care order and had thought it was written for daily wound care and every shift wound observation. The Wound Care Nurse confirmed Resident #3's wound care was not provided every shift as written by the provider for several dates in April and May 2025. The facility policy titled Prevention of Pressure Ulcers/Injuries, adopted 02/01/2019, documented the resident's skin would be inspected daily when performing or assisting with personal care. Identify any signs of developing pressure injuries and inspect pressure points such as sacrum, heels, buttocks, coccyx, elbow, etc). Prevention included following the plan of care and identified interventions. Monitoring included evaluating, reporting, and documenting potential skin changes. The facility policy titled Skin and Wound Management, adopted 02/01/2019, documented any resident who entered the facility without pressure ulcers would have appropriate preventive measures taken to ensure the resident did not develop pressure ulcers. The Physician was notified of the development of pressure ulcers and treatment would be initiated as ordered. The wound treatment nurse would audit the orders weekly with the DON or Unit Manager Nurse. Treatment record reviews would be conducted to ensure the administration of treatments as prescribed.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and document review the facility failed to ensure a resident's gastric residual volume (the amount of fluid remaining in the stomach) was checked prior to administration of a medication via the resident's gastrostomy tube (a feeding tube providing a direct path to the stomach for delivering nutrition, fluids, and medications) (G-tube) for 1 of 32 sampled residents (Resident #84). This deficient practice had the potential for delayed gastric emptying to not be recognized in a resident with the potential to result in aspiration pneumonia (a type of lung infection due to inhaling substances into the lungs). Findings include: Resident #84 Resident #84 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including dysphagia, oropharyngeal phase, gastroparesis, and gastrostomy status. On 05/12/2024 at 11:23 AM, Resident #84 was resting in bed and had a tube feeding pump administering formula to a G-tube. A Physician's Order for Resident #84, dated 02/20/2023, documented to check for residual prior to administration of water, medications, and formula through the G-tube. A Physician's order for Resident #84, dated 02/20/2023, documented levetiracetam solution 100 milligrams (mg) per milliliter (ml) give 5 ml via G-tube three times a day. On 05/13/2025 at 1:57 PM, the Licensed Practical Nurse (LPN) for Resident #84 administered the levetiracetam via the resident's G-tube but did not check residual prior to administration. On 05/13/2025 at 2:00 PM, the LPN confirmed the LPN had not checked residual prior to administration of the medication and residual should have been checked prior to administering medication via the G-tube. On 05/13/2025 at 2:52 PM, the Director of Nursing (DON) verbalized residual should be checked prior to administering anything through a G-tube to ensure the G-tube is patent and had the appropriate placement. The facility policy titled, Enteral Feedings - Safety Precautions, adopted 02/01/2019, documented to prevent aspiration enteral tube placement would be checked prior to administration of medication and gastric residual volume would be checked as ordered.

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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** Based on observation, interview, clinical record review, and document review, the facility failed to ensure there were no discrepancies between a resident's available medications and the resident's medication orders and medication administration record (MAR) for 1 of 32 sampled residents (Resident #19). This deficient practice had the potential to result in a resident not receiving medications the resident could have potentially needed to alleviate symptoms of anxiety, agitation, restlessness, nausea, and vomiting. Findings include: Resident #19 Resident #19 was admitted to the facility on [DATE], with diagnoses including anxiety disorder, unspecified and encounter for palliative care. On 05/15/2025 at 8:30 AM, during a review of Resident #19's medications with the resident's Registered Nurse (RN) the resident had a 30 milliliter (ml) bottle of lorazepam 2 milligrams (mg) per ml concentration located in the medication storage room. The label documented the medication had been prescribed for Resident #19 with the direction to administer 0.25 ml under the tongue every 30 minutes as needed for anxiety, agitation, and/or restlessness. The RN verbalized the medication had been delivered to the facility from the pharmacy used by the resident's hospice agency. The RN confirmed the facility's electronic health record did not include an order for the lorazepam and the medication was not listed on the resident's MAR. The Order Review History Report for Resident #19 documented an order for C-PDR 25/2/10 mg cream, apply 1 ml to skin every six hours as needed for nausea or vomiting (part of comfort package of hospice). On 08/15/2025 at 8:34 AM, the RN for Resident #19 verbalized the facility did not have the C-PDR cream for Resident #19. On 05/15/2025 at 8:41AM, the Director of Nursing (DON) verbalized all medications ordered for a resident should have been available in the facility. The facility policy titled Medication Orders, adopted 02/01/2019, documented the facility would establish uniform guidelines in the receiving and recording of medication orders. A current list of orders would be maintained in the clinical record for each resident. A Pharmacy Services Contract Amendment, dated 12/22/2021, documented the standard services included monthly visits by a Consultant Pharmacist to conduct a medication regimen review for each resident. The facility staff would provide the Consultant Pharmacist with access to medication storage areas, including those secured or locked areas. Cross reference with tag F849

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure an unattended medication cart was not left unlocked with the keys to the medication cart on top of the cart for 1 of 1 medication carts in use on the 300 hall. This deficient practice had the potential to result in facility residents accessing and ingesting medications with the potential for severe or lethal consequences and unauthorized individuals having access to resident's medications. Findings include: On 05/14/2025 at 7:22 AM, a medication cart was against the wall in the 300 hall, next to room [ROOM NUMBER], with the drawers facing the hallway. The medication cart was unlocked, and the medication cart keys were on top of the cart. There were no staff members in sight of the cart. On 05/14/2025 at 7:24 AM, a Registered Nurse (RN) came out of room [ROOM NUMBER] and confirmed the medication cart had been left unlocked with the keys for the medication cart on top of the cart while the cart was unattended and out of sight. On 05/14/2025 at 1:55 PM, the Director of Nursing verbalized the correct procedure for leaving a medication cart unattended was for the medication cart to be locked and the medication cart keys would always be with the nurse. The facility policy titled Storage of Medications, adopted 02/01/2019, documented the nursing staff would be responsible for maintaining medication storage in a safe manner. Compartments including drawers and carts, containing drugs and biologicals would be locked when not in use, and carts used to transport such items would not be left unattended if open or otherwise potentially available to others. Only persons authorized to prepare and administer medications would have access to the medication room, including any keys.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and document review, the facility failed to ensure the facility coordinated care and services with a hospice agency providing care and medications to a resident residing in the facility for 1 of 32 sampled residents (Resident #19). This deficient practice had the potential to result in a resident not receiving care or medications as ordered due to a lack of coordination and communication between the facility and hospice agency with the potential for the resident to suffer neglect or end-of-life symptoms not managed by facility staff. Findings include: Resident #19 Resident #19 was admitted to the facility on [DATE], with diagnoses including encounter for palliative care and anxiety disorder, unspecified. On 05/12/2025 at 2:12 PM, the representative for Resident #19 verbalized the resident had a large mass on the resident's breast and the mass was tunnelling. The representative verbalized the resident was on hospice and the hospice staff were caring for the resident's wound. A Nursing Visit Record from the hospice agency, dated 05/09/2025, documented initial visit of the week. Wound care was performed on the right breast. Upon removal of the dressing, dried sanguineous (containing blood) drainage was noted, and the site began to bleed slightly. Wound edges were macerated (a softening and breaking down of skin resulting from prolonged exposure to moisture). The area was cleansed with a wound cleanser and Medihoney (a medical-grade, honey-based wound care dressing) was applied. The dressing was replaced. According to the facility Registered Nurse (RN) the resident received a bath from the Certified Nursing Assistant (CNA), but the resident and the CNA visit log deny resident received a bath. The hospice agency's Wound Care Plan, dated 05/09/2025, documented the following: - Cleanser: Normal saline and wound cleanser. - Dressing: Foam. - Frequency of dressing change: Every two to three days. Two times a week or as needed if soiled. - Additional measures, teaching, and details: The facility RNs would facilitate. An Interdisciplinary Group Meeting Document from the hospice agency, dated 05/07/2025, and signed by the hospice physician documented the resident was declining as evidenced by a non-healing wound on the right breast. The Physician Orders located in the facility's Electronic Health Record (EHR) did not include an order for wound care. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician Orders located in the facility's EHR included the following discrepancies when compared with the orders from the contracted hospice agency: - The facility EHR included an order for metronidazole oral tablet 500 milligrams (mg), apply to right breast topically every 24 hours as needed for right breast wound crush and mix with saline and apply to wound bed every day. The start date for the order was 04/30/2025. - The hospice agency's list of Active Medications included metronidazole 375 mg, dissolve one capsule to the affected area as directed as needed. Mix the capsule with saline to put onto wound bed of right breast. The start date for the order was 04/25/2025. - The facility EHR included an order for pravastatin sodium tablet 40 mg, give one tablet by mouth at bedtime. The start date for the medication was 04/17/2025. - The hospice agency's list of Active Medications did not include an order for pravastatin. - The facility EHR did not include an order for lorazepam. - The hospice agency's list of Active Medications included lorazepam 2 mg/milliliter (ml) concentrate, take 0. 25 ml by mouth every 30 minutes as needed. Give 0.25 ml under the tongue every 30 minutes as needed for anxiety, agitation, and/or restlessness. The facility EHR and the hospice agency's list of Active Medications documented an order for PDR cream, apply one pump to skin every six hours as needed for nausea and vomiting. The facility's Care Plan for Resident #19 did not include a care plan for the resident's wound care or the use of lorazepam and PDR cream to manage the resident's symptoms. On 05/14/2025 at 3:48 PM, an RN for the resident verbalized the resident was on hospice. The RN verbalized there were no wound care orders or wound care plans in the facility's electronic health record. On 05/15/2025 at 8:00 AM, the RN Case Manager (CM) for Resident #19 from the contracted hospice agency confirmed the metronidazole dosage ordered by the hospice agency did not match the dosage ordered by the facility and the hospice list of active medications included lorazepam but did not include pravastatin. The RNCM verbalized the RNCM completed wound care for Resident #19 at each visit and the dressing in place at the start of each visit was the same dressing applied by the RNCM at the last visit. The RNCM explained the RNCM would always ask the facility nurse if the resident needed any medications but did not look at the medications available or count the medications available with the facility nurse. On 05/15/2025 at 8:30 AM, medications for Resident #19 were reviewed with the resident's RN. The resident's medications included metronidazole 500 mg capsules, pravastatin 40 mg tablets, and a 30 ml bottle of lorazepam 2 mg/ml. The medications for Resident #19 did not include a tube of PDR cream. The resident's RN confirmed the facility did not have PDR cream available, the metronidazole order did not match the hospice order, the hospice orders did not include pravastatin, and the facility did not have an order for the lorazepam. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/15/2025 at 8:41 AM, the Director of Nursing (DON) verbalized the facility staff should have reconciled medications, care plans, and orders with the contracted hospice agency. The DON verbalized the facility did not have a hospice coordinator. On 05/15/2025 at 8:46 AM, the Unit Manager (UM) verbalized hospice agencies sent new orders to the medical records department and medical records would notify nursing of new orders. The UM confirmed the facility did not have a care plan for the resident's wound. The facility policy titled Hospice Program, adopted 02/01/2019, documented it was the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative and ensure the level of care provided was appropriately based on the individual resident's needs. These included administering prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care. The facility had designated the DON to coordinate care provided to the resident by the facility staff and the hospice staff. The DON would be responsible for collaborating with hospice representatives and coordinating facility staff participation in the hospice care planning process for residents receiving those services. Ensuring quality of care for the resident, ensuring the facility communicated with the hospice medical director, the resident's attending physician, and other practitioners participating in the provision of care to the resident. The DON would obtain hospice medication information specific to the resident and any orders specific to the resident. Coordinated care plans for residents receiving hospice services would include the most recent hospice plan of care as well as the care and services provided by the facility. Cross reference with tags F656, F684, F755

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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** Based on observation, interview and document review the facility failed to ensure a staff member conducted hand hygiene prior to entering a room on enhanced barrier precautions (EBP) for 1 of 44 rooms on EBP and for 1 of 32 sampled residents (Resident #73). This deficient practice had the potential to affect the resident population. Findings include: Resident #73 Resident #73 was admitted to the facility on [DATE], with diagnoses including extended-spectrum beta-lactamase (ESBL) resistance and urinary tract infection (UTI), site not specified. A physician's order dated 05/12/2025, documented EBP for ESBL in urine, every shift. On 05/14/2025 at 8:11 AM, a Certified Nursing Assistant (CNA) entered room [ROOM NUMBER] without having used alcohol-based hand rub (ABHR) or having washed hands. A sign outside the door identified the room as having been on EBP. ABHR was in a dispenser hanging on the wall outside the room. On 05/14/2025 at 8:12 AM, the CNA confirmed not having used ABHR or washing hands prior to entering room [ROOM NUMBER] to assist Resident #73 with the resident's meal tray but should have as the resident had been on EBP due to a UTI. The CNA verbalized having forgotten to use ABHR before entering the room. On 05/14/2025 at 8:16 AM, a Registered Nurse (RN) confirmed having observed the CNA enter room [ROOM NUMBER] without performing proper hand hygiene. The RN confirmed Resident #73 had been on EBP due to ESBL in the urine. On 05/14/2025 at 10:36 AM, the Administrator confirmed the CNA should have performed hand hygiene prior to entering a room on EBP. The facility policy titled, Enhanced Barrier Precautions (EBP), updated 03/21/2024, documented every person entering a room on EBP must clean hands with ABHR prior to entering the room. The Center for Disease Control and Prevention (CDC) defined EBP as an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. An example of a MDRO is ESBL. The focus is on the use of gown and gloves and adherence to other recommended infection prevention practices including performing hand hygiene.