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	06/25/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review, and document review, the facility failed to ensure a consent was obtained for an opioid pain medication for 1 of 31 sampled residents (Resident #137). This deficient practice had the potential to result in the resident receiving an opioid medication without having been informed of the risks, benefits, and alternatives, and an opportunity to make an informed decision.Findings include: Resident #137 Resident #137 was admitted to the facility on [DATE], with a diagnosis of bilateral primary osteoarthritis of knee. A physician's order dated 06/19/2026, documented Hydrocodone-Acetaminophen Oral Tablet, 10-325 Milligrams (mg), give one tablet by mouth every four hours, as needed, for pain management related to bilateral primary osteoarthritis of knee. Resident #137's Medication Administration Record dated June 2026, documented Hydrocodone-Acetaminophen Oral Tablet, 10-325 mg, was administered on 06/19/2026, 06/20/2026, 06/21/2026, 06/22/2026, 06/23/2026, and 06/24/2026. On 06/24/2026 at 2:32 PM, the [NAME] President of Clinical Services verbalized not having been able to locate a signed consent for Resident #137's Hydrocodone-Acetaminophen medication. On 06/25/2026, at 12:11 PM, the Director of Nursing (DON) confirmed a consent had not been obtained from Resident #137 for the Hydrocodone-Acetaminophen Oral Tablet prior to administration of the medication. The DON confirmed a consent should have been obtained to ensure the resident was aware of the risks and benefits of the medication. The facility policy titled, Pain Assessment and Management, dated 02/01/2019, documented an informed consent would be obtained from the resident at the start of a prescribed opioid pain medication and pain management interventions would be consistent with the residents goals for treatment.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, and document review, the facility failed to accommodate the needs and preferences for 1 of 31 sampled residents (Resident #26) when the resident requested to get out of bed. This deficient practice had the potential to result in a decline in functional mobility, feelings of isolation and harm to the resident. Findings include:Resident #26 Resident #26 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including polyneuropathy, unspecified, ankylosing spondylitis of unspecified sites in spine, unspecified osteoarthritis, and spinal stenosis, thoracic region. A physician's order, dated 04/24/2026, documented the resident was to get up in the chair every day per resident and doctor. A care plan focus, initiated 03/06/2025, documented Resident #26 had alterations in physical mobility related to impaired balance, weakness, pain, and decreased activity tolerance. A care plan intervention, initiated 03/06/2025, documented transfer equipment to use included a Hoyer Lift and two staff. A Documentation Survey Report for CNA task notes, dated 06/25/2026, documented an intervention of bed to chair transfer did not occur on the following dates in 2026:May 01, 02, 03, 06, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 20, 21, 22, 23, 25, 26, 28, 29, and 30.June 02, 06, 07, 08, 10, 12, 13, 14, 15, 20, 21, and 22. On 06/22/2026 at 11:37 AM, Resident #26 was in the resident's bed in the resident's room. Resident #26 verbalized the resident wanted to get out of bed once or more per day; however, was unable to. When the resident requested to transfer into a wheelchair, staff often denied the transfer and informed the resident the facility was short staffed. On shower days, the facility believed the shower was the same as a transfer and the resident would not be assisted into the resident's wheelchair. The resident relied on staff assistance transferring from the bed to the wheelchair and from the wheelchair to the bed. The resident verbalized wanting to get out of bed daily, but often being told the facility was too short-staffed. The resident was assisted out of bed twice weekly for showers. The resident verbalized the resident complained to the physician and subsequently received an order to be assisted into the wheelchair daily. Resident #26 explained the resident would like to get out of bed more often to retain the resident's strength. On 06/24/2026 at 12:30 PM, a Certified Nursing Assistant (CNA) explained Resident #26 depended on staff for assistance transferring from the bed to the wheelchair and from the wheelchair to the bed. The CNA explained a physician's order requested daily transfers; however, staff were not always able to accommodate due to short staffing and instead assisted Resident #26 out from bed approximately three times weekly. The CNA verbalized the resident was always in bed and looked forward to transfers from the wheelchair. On 06/24/2026 at 1:43 PM, a Licensed Practical Nurse (LPN) explained Resident #26 required two person Hoyer Lift transfer assistance. The resident's preference was to be up in a wheelchair, however there was not always enough staff to accommodate daily transfers. The LPN confirmed the resident was assisted out of bed at minimum twice per week for showers. On 06/25/2026 at 8:55 AM, the Director of Nursing (DON) verbalized Resident #26's diagnoses of polyneuropathy, spinal stenosis, osteoarthritis and spondylitis made it difficult for the resident to transfer to a wheelchair without assistance. The resident required two CNAs and a Hoyer Lift to get out of bed. Resident #26's physician recently placed a treatment order for staff to assist the resident up into a chair once a day. The DON explained CNAs were responsible to document activities in the CNA tasks and confirmed the CNA task notes documented bed to chair transfers did not occur as ordered by the physician. The facility policy, titled Activities of Daily Living (ADLs), Supporting, dated 02/01/2019, documented appropriate care and services would be provided for residents unable to carry out ADLs independently with the consent of the resident and in accordance with the plan of care, including mobility related to transfer and ambulation. The facility policy titled Resident Rights, dated 02/01/2019, documented the resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when to do so would endanger the health or safety of the resident or other residents. The resident had the right to make choices about aspects of their life in the facility significant to the resident.

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **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 was afforded the choice of wearing an identification wrist band for 1 of 31 sampled residents (Resident #23). This deficient practice had the potential to impede a resident's self-determination and right to make choices about aspects of the resident's daily life.Findings include: Resident #23 Resident #23 was admitted to the facility on [DATE], with diagnoses including chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, unspecified, pulmonary hypertension, unspecified, and dependence on supplemental oxygen. On 06/22/2026 at 9:03 AM, Resident #23 was sitting on the side of the resident's bed. The resident had a plastic wrist band on the resident's left wrist. The wrist band documented the resident's name, room number, and allergies. On 06/22/2026 at 9:04 AM, Resident #23 verbalized the resident did not want to wear the wristband and had asked the facility to remove the wristband several times. The resident verbalized the Unit Manager Licensed Practical Nurse (LPN) would ensure the resident was wearing the wristband at all times and the Unit Manager LPN would, have a fit, if the resident was found not wearing the wrist band. On 06/23/2026 at 11:43 AM, the Unit Manager LPN confirmed Resident #23 had been requesting the wristband removed since February 2025. The Unit Manager LPN verbalized having been responsible for completing monthly audits to ensure each resident had been wearing the wristband and the information on the wristband was correct. The Unit Manager LPN verbalized having been informed during a staff meeting on the morning of 06/23/2026, if a resident did not want to wear the wristband, the wristband was to be removed, and the removal was to be documented in the resident's care plan. On 06/24/2026 at 8:21 AM, Resident #23 was in the resident's room. The wristband was still on the resident's left wrist. On 06/24/2026 at 10:26 AM, the Registered Nurse, completing medication administration on the unit, verbalized the wristbands were a double check for accurate medication administration. On 06/25/2026 at 11:57 AM, the Director of Nursing (DON) confirmed residents were asked to wear the wristband for verification during medication administration and Unit Managers were to ensure residents were wearing the wristbands. The DON verbalized not having been aware of any new instructions related to residents not wanting to wear the wristband, or of Resident #23's request not to wear it. On 06/25/2026 at 12:34 PM, Resident #23 was in the resident's room. The wristband was still on the resident's left wrist. On 06/25/2026 at 12:35 PM, Resident #23 verbalized no one from the facility had spoken to the resident about removing the wristband. On 06/25/2026 at 1:37 PM, the Administrator confirmed the wristbands were a secondary check for medication administration and verbalized the instruction to remove the wristband, if a resident did not want to wear it and to document the removal in the resident's care plan, had not been disseminated to the nursing staff or the Unit Manager's yet. The facility policy titled, Quality of Life-Resident Self-Determination and Participation, dated 02/01/2019, documented the facility promoted the right of each resident to exercise their autonomy regarding what was important to the resident and each resident was allowed to choose and participate in their health care needs consistent with their interests and choices. The facility policy titled, Resident Rights, dated 02/01/2019, documented a resident had the right to self-determination related to services provided by the facility and the resident had the right to make choices about aspects of the resident's life that were significant to the resident.

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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 with a history of physical and verbal aggression towards other residents had a care plan addressing the aggression implemented for a resident involved in 1 of 5 Facility Reported Incidents (FRI) investigated (Resident #43) and a resident's wound care plan was implemented for 1 of 31 sampled residents (Resident #56). These deficient practices had the potential to result in the resident continuing aggressive behaviors and causing the resident to suffer psychosocial harm from unaddressed behaviors and to negatively impact the physical and psychosocial well-being of other residents in the facility and a resident's wound worsening or becoming infected due to staff not implementing the care plan to complete wound care as ordered.Findings include: Physical and Verbal Aggression Resident #43 Resident #43 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including major depressive disorder, recurrent, moderate and essential (primary) hypertension. A FRI for physical abuse submitted by the facility on 04/26/2026, documented the following: Nursing staff reported having heard an altercation in the activity room. A Nurse responded to the area and found Resident #43 had punched another resident on the left side of the resident's face. A progress note for Resident #43, dated 04/26/2026, documented the resident had physically hit another resident in the activity room. The resident stated, I don't care that I did that. A progress note for Resident #43, dated 06/20/2026, documented the resident was observed yelling and using foul language in the hallway. The resident was upset because another resident was wheeling around the hallway and Resident #43 believed the resident was too close. The resident became verbally aggressive and yelled at staff. The Care Plan for Resident #43 included a care plan initiated on 04/26/2026. The focus of the care plan was Resident #43 demonstrated being physically aggressive by punching another resident related to anger and poor impulse control. The interventions/tasks included Licensed Practical Nurses, Registered Nurses, and Social Workers would analyze and document the times of day, places, circumstances, and triggers for the resident's aggressive behaviors, and document what de-escalated the resident's behaviors. On 06/25/2026 at 8:33 AM, the Director of Nursing (DON) verbalized the care planned interventions would be documented under the task for Regressive Behavior - Yelling out and/or At Others. The data entered in the tasks would be used to analyze the resident's behavior patterns and determine triggers. The DON verbalized the resident's clinical record and treatment plan did not include methods staff would utilize to de-escalate the resident's aggressive behaviors.The Regressive Behavior Task, dated 06/20/2026, documented the resident had not exhibited regressive behavior on 06/20/2026.The DON confirmed the resident had exhibited behaviors when the resident had been verbally aggressive on 06/20/2026, and the behaviors were directed towards another resident and staff. The DON verbalized it was important to accurately document the care planned interventions, per the care plan, to ensure the resident's behaviors could be analyzed to determine triggers and methods to de-escalate in order to update the resident's treatment plan.Wound CareResident #56 Resident #56 was admitted to the facility on [DATE], with diagnoses including unspecified open wound, right foot, subsequent encounter and other acute osteomyelitis, right ankle and foot. On 06/22/2026 at 1:30 PM, the resident verbalized the resident had injured the resident's foot recently. The resident verbalized the resident was not sure what had happened, but the resident's foot had started bleeding. A Nursing Narrative Note for Resident #56, dated 06/09/2026, documented a Certified Nursing Assistant (CNA) had noticed bright, red blood on the floor of the resident's room. The bleeding was from the heel of the resident's right foot. An order for Resident #56, dated 06/10/2026, documented to cleanse the open area to the right heel, apply xeroform followed by an abdominal (ABD) pad and then wrap with a woven gauze bandage (Kerlix) and secure with an elastic bandage (ACE wrap). A care plan for (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #56, initiated 06/10/2026, documented the resident had an actual alteration in skin related to a right heel wound. Interventions included administering treatments as ordered and monitor for effectiveness. The June 2026 Treatment Administration Record (TAR), documented to cleanse small open area to the right heel, apply xeroform followed by an ABD pad and then wrap with Kerlix and secure with an ACE wrap in the morning every Monday, Wednesday, and Friday. The treatment was documented as completed on Monday 06/22/2026. On 06/23/2026 at 2:57 PM, the Wound Care Licensed Practical Nurse (LPN) verbalized the wound care for the traumatic wound on Resident #56's heel was the responsibility of the floor nurse. The Wound Care LPN verbalized the LPN primarily performed wound care for complex or worsening wounds and minor injuries such as the wound on Resident #56's heel would be the responsibility of the floor nurse assigned to the resident. On 06/23/2026 at 3:17 PM, the floor nurse (LPN2) assigned to Resident #56 verbalized the LPN2 had been assigned to the resident on 06/22/2026. The LPN2 verbalized the LPN had not seen the resident's wound and had not performed wound care on Resident #56 as the Wound Care LPN was managing the resident's wound. On 06/23/2026 at 3:28 PM, the Wound Care LPN confirmed the Wound Care LPN was not performing Resident #56's wound care. The Wound Care LPN assessed Resident #56's right heel and confirmed the resident did not have a dressing to the resident's heel. The Wound Care LPN confirmed the wound care had been documented as completed on 06/22/2026, by the floor nurse. On 06/23/2026 at 3:40 PM, the DON verbalized the wound care should not have been documented as complete by the floor nurse unless the nurse had completed the wound care. The DON verbalized it was important to follow wound care orders and document accurately to ensure the resident did not develop an infection and the wound did not worsen. The DON confirmed staff were responsible for reviewing and implementing the care plan. The facility policy titled, Care Plan, Comprehensive Person-Centered, adopted 02/01/2019, documented the comprehensive, person-centered care plan would include measurable objectives and timeframes, describe the services to be furnished to attain or maintain the resident's highest practicable mental and psychosocial well-being, incorporate identified problem areas and risk factors, and build on resident's strengths. Care plan interventions were chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. Cross reference with tag F600 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, clinical record review, interviews, and document review, the facility failed to ensure professional standards of quality were maintained when medications were left at residents' bedsides and when pain management practices did not adhere to professional standards for 3 of 31 sampled residents (Residents #137, #133, and #6). This deficient practice had the potential to result in unverified and unsupervised medication administration, medication misuse or diversion, adverse medication outcomes, and inadequate pain management. Findings include:Resident #137 Resident #137 was admitted to the facility on [DATE], with diagnoses including chronic respiratory failure with hypoxia, pulmonary hypertension, unspecified, bilateral primary osteoarthritis of knee, type II diabetes mellitus with diabetic neuropathy, unspecified, anxiety disorder unspecified, major depressive disorder, recurrent, unspecified, unspecified mood (affective) disorder, essential (primary) hypertension, hypothyroidism, unspecified, and unspecified diastolic (congestive) heart failure. On 06/22/2026 at 8:38 AM, the door to Resident #137's room was closed and the resident was the only resident assigned to the room. Resident #137 was lying on the resident's side in bed. Two small medication cups, both containing an assortment of pills of different colors and shapes, and one larger medication cup containing a liquid, were located on top of the tray table next to the resident's bed. On 06/22/2026 at 8:39 AM, Resident #137 verbalized the nurse had left the medications on the tray table for the resident to take on their own. The resident confirmed the pills in both cups were the resident's morning medications and the liquid was liquid potassium. The resident verbalized the nurse often left medications on the tray table, and the resident would sometimes wake up and find the medications left on the table from the previous day. The resident verbalized, just throwing the meds away, if they were left overnight. Resident #137's care plan, last updated 12/10/2025, documented medications were to be administered as ordered by the physician. Resident #137's clinical record lacked documentation in the resident's care plan or of a physician order for the resident to self-administer medications. Resident #137's physician orders for medications to have been administered in the morning were as follows and documented on the resident's Medication Administration Record as having been administered the morning of 06/22/2026: -12/01/2025, Propranolol Hydrochloride Tablet, 10 MG, give three tablets by mouth every 8 hours for hyperthyroidism (three tabs =30MG), (hold for systolic blood pressure less than 100 millimeters of mercury (mmHg), diastolic blood pressure less than 60 mmHg, and heart rate less than 60 beats per minute). -12/02/2025, Folic Acid Oral Tablet 400 micrograms (MCG), give two tablets by mouth in the morning for supplementation (two tabs=800 MCG). -12/02/2025, Methimazole Oral Tablet, 10 MG, give one tablet by mouth in the morning for hyperthyroidism. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-12/02/2025, Multi Vitamin Oral Tablet, give one tablet by mouth in the morning for supplementation. -12/02/2025, Furosemide Oral Tablet 80 MG, give one tablet orally two times a day for diastolic congestive heart failure (take twice daily at 8:00 AM and 2:00 PM). -12/03/2025, Ascorbic Acid Oral Tablet, 500 milligrams (MG), give one tablet by mouth in the morning for supplementation. -12/05/2025, Senna Oral Tablet 8.6 MG, give one tablet by mouth two times a day for constipation. -12/11/2025, Aspirin Enteric Coated Tablet Delayed Release, 81 MG, give one tablet by mouth one time a day for peripheral artery disease. -12/11/2025, Atorvastatin Calcium Tablet, 20 MG, give one tablet by mouth one time a day for peripheral artery disease. -12/11/2025, Spironolactone Oral Tablet, 25 MG, give two tablets by mouth in the morning for diastolic congestive heart failure. -12/20/2025, MiraLAX Oral Powder 17 Grams (GM)/SCOOP, give one scoop by mouth in the morning for constipation. -01/01/2026, Fluoxetine Hydrochloride Oral Tablet, 80 MG, give one tablet by mouth in the morning for depression. -01/01/2026, Metformin Hydrochloride Extended-Release Oral Tablet 24 Hour, 500 MG, give one tablet by mouth in the morning for hyperglycemia. -03/07/2026, Omeprazole Oral Capsule Delayed Release, 20 MG, give one capsule by mouth in the morning for gastroesophageal reflux disease. Do not Crush. -03/09/2026, Potassium Chloride Oral Packet, 20 milliequivalent (MEQ), give one packet by mouth one time a day for potassium loss due to diuretic use. -03/14/2026, Loratadine Oral Capsule, 10 MG, give one capsule by mouth one time a day. -04/25/2026, Bupropion Hydrochloride Oral Tablet, 5 MG, give 2.5 tablets (12.5 MG) by mouth in the morning for anxiety. On 06/24/2026 at 8:31 AM, the Licensed Practical Nurse (LPN) confirmed having left the medications on Resident #137's tray table as the resident was alert and able to take the medications on their own. The LPN confirmed the LPN should have waited and watched the resident consume the medications to ensure the resident received all physician ordered medications. On 06/24/2026 at 8:39 AM, the Director of Nursing (DON) verbalized medications were not to be left at the bedside for residents to take on their own and could result in missed administrations and potential negative adverse effects to the resident. The DON confirmed having been aware of the LPN leaving medications at Resident #137's bedside. The DON verbalized the facility applied the Fundamentals of Nursing, by [NAME] and [NAME], as the standards of practice. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/25/2026 at 9:31 AM, the Administrator verbalized medications were to be visualized by the administering nurse to ensure residents took the medications per the physician orders. The Administrator verbalized medications were not to be left at the resident's bedside as the resident could potentially have an adverse effect by not taking the medication or potentially overdosing. The facility policy titled, Liberalized Medication Administration-Policy and Procedure, dated 02/2023, documented medications would be administered in a safe manner and per physician orders. Resident #133 Resident #133 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including active primary progressive multiple sclerosis, unspecified severe protein-calorie malnutrition, and fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing. On 06/25/2026 at 8:56 AM, located in Resident #133 room, on a table next to the resident's bed, was a cup of unknown pills. There was not a nurse within line of sight nor within the resident's room. Resident #133 explained the pills were left with the resident by the RN. On 06/25/2026 at 9:01 AM, the RN was walking into a residents room to administer medications to the resident. The RN waited with the resident until all medications were swallowed. On 06/25/2026 at 9:04 AM, the RN explained when administering medications, make sure you have the right resident, right medication, and right dosage. Once confirmed, watch the resident take the medications. The RN explained medications were not to be left with the resident. The RN entered Resident #133's room and confirmed there was a cup of medications, unattended and unsecured, on the resident's side table. The RN verbalized leaving the medications with the resident because there were no controlled medications in the cup and the RN had faith Resident #133 would take the medications. The RN confirmed leaving the medications unattended and out of the line of sight with Resident #133 in the room. The RN did not leave the resident's room verbalizing I have to watch the resident take the medications now. On 06/25/2026 at 9:16 AM, the DON explained when administering medications, the nurse must ensure the nurse knocks on the residents room prior to entering, the RN needs to introduce themselves to the resident, make sure the right person is being administered the medications, follow the parameters of administration, and make sure the resident swallows the medications prior to leaving the residents room. The DON verbalized if a nurse did not ensure a resident took their medications, it could alter a residents health and cause a negative impact. Failure to do so could result in false monitoring of a medication and false side effects of a medication. There would also be a potential other residents could take the medications not belonging to them and that residents health could worsen. The facility policy titled Liberalized Medication Administration-Policy & Procedure (Alta), undated, documented the facility was to administer medications to residents in a safe manner but in a way that correlated with daily activities and natural schedules. The facility would properly assess residents and plan care to meet the residents needs. Medications would be administered in a safe manner and per physician orders. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Fundamentals of Nursing, by [NAME] and [NAME], Twelfth Edition, Copyright 2026, Section Medication Administration, documented medications were to be administered per physician orders and to enhance accuracy and resident safety, nurses were required to administer all medications rather than allowing residents to self-administer. Failing to administer medication properly was a medication error. Resident #6 Resident #6 was admitted to the facility on [DATE] and readmitted on [DATE] and 03/27/2025, with diagnoses including hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting the right dominant side, major depressive disorder, recurrent, unspecified, and intentional self^harm by other specified means, initial encounter. A Psychiatric Follow^Up Progress Note dated 05/14/2026, documented Resident #6 possessed bags of partially decomposed narcotic pills the resident verbalized the pills were being saved for a transfer to another facility. The resident denied suicidal intent. A Nursing Progress Note dated 05/26/2026, documented the resident continued hoarding pain pills due to frustration about not receiving a pain pump. On 06/24/2026 at 8:19 AM, Resident #6 explained a Registered Nurse (RN) would leave oxycodone and morphine pills with the resident and leave the resident's room. The resident verbalized pills were hoarded without staff knowledge and kept so pain could be self^managed if staff were unavailable. A physician's order dated 06/20/2026, documented Morphine Sulfate Extended Release oral tablet, 15 milligram (mg). Give one tablet by mouth three times a day for chronic pain; pain management for 30 days for a diagnosis of chronic pain syndrome. A physician's order dated 06/19/2026, documented Oxycodone HCl oral tablet 10 mg. Give one capsule by mouth two times a day for chronic pain; pain managed for 30 days until finished for a diagnosis of chronic pain syndrome. Resident #6's clinical record lacked documented evidence the resident was able to self-administer medicaitons. On 06/24/2026 at 8:56 AM, the Unit Manger LPN explained a staff member discovered unsecured medications in the resident room and reported the finding to the Unit Manager LPN. The Unit Manager LPN recalled approximately 15 pain pills were present and could not describe how the medications were destroyed. The Unit Manager LPN verbalized staff had no idea how the resident obtained and hoarded pain pills. The Unit Manager LPN verbalized licensed nurses were required to bring medications into the resident's room, confirm correct resident, explain medications, observe ingestion, and remain with the resident until medications were swallowed. The Unit Manager LPN explained the resident was supposed to receive a pain pump months earlier but cancelled the resident's travel due to unforeseen circumstances. The resident was cheeking the pain pills when the nurses would attempt to administer and spit the pills out to hoard after the nurses left the resident's room. The Unit Manager LPN reported the pills appeared wet and discolored. The Unit (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Manager LPN verbalized nurses were never permitted to leave medications with residents and no staff admitted to leaving medications unattended. On 06/24/2026 at 9:01 AM, the DON verbalized nurses were reminded during meetings to ensure residents swallowed medications. The DON verbalized mouth checks were only performed if a resident had a history of not swallowing medications; however, Resident #6 had no history of cheeking medications prior to the incident. On 06/24/2026 at 9:02 AM, the Unit Manger LPN verbalized Resident #6 possessed oxycodone and morphine. The Unit Manager LPN explained nurses were not administering or monitoring medication ingestion any differently after the incident. The Unit Manager LPN confirmed the resident's oxycodone and morphine pills were unsecured in the facility and accessible to residents and staff. The Unit Manager LPN approximated three days of the resident hoarding pain medications in the resident's room and wondered if the resident had any actual pain throughout the resident's body. The Unit Manager LPN verbalized the Unit Manager LPN often wondered if the pain Resident #6 claimed to have was true and accurate. Resident #6's Pain Evaluations dated 09/18/2025 and 04/28/2026, documented the resident had a pain frequence almost constantly. The pain had an effect sleep, therapy activities, and day to day activities. On 06/24/2026 at 10:57 AM, the DON explained pain assessments were conducted at admission, every shift, and during medication administration. Pain assessments were also completed quarterly as part of the Minimum Data Set (MDS). The DON verbalized pain discussions occurred during clinical meetings but were not documented in Interdisciplinary Team Meeting (IDT) notes. The DON explained the resident's pain was associated with stroke, chronic low back pain, polyneuropathy, migraines, and chronic pain syndrome. The resident received gabapentin three times daily, methocarbamol every eight hours as needed, oxycodone every four hours as needed, pregabalin twice daily, and morphine extended release three times daily. The DON verbalized pain management was essential for the psychosocial wellˆbeing, Activities of Daily Living (ADL), sleep, and rehabilitation participation for the resident. The DON verbalized nonˆpharmacological interventions were minimal since the resident was cognitive and primarily involved redirection. The DON explained if Resident #6 had not taken the resident's pain pills for three days, the resident would experience high levels of pain and even after administration on the fourth day, the pain pills would likely not be effective in relieving the resident's pain. The DON verbalized Resident #6 experienced pain daily and confirmed it was not appropriate for nurses to suggest a resident was not in pain, as pain was subjective and must be respected, and the resident was not administered pain pills according to the physician order. The facility policy titled Pain Assessment and Management, adopted 02/01/2019, documented the pain management program was based on a facility-wide commitment to resident comfort. Staff would be trained on recognizing pain, assessing pain, identifying causes of pain, defining goals and appropriate interventions, implementing pain management strategies, monitoring and modifying approaches, documenting pain, and reporting any significant changes in the residents pain levels. Medications would be administered in a safe manner and per the physician's orders. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Fundamentals of Nursing, by [NAME] and [NAME], Twelfth Edition, Copyright 2026, Section Medication Administration, documented medications were to be administered per physician orders and to enhance accuracy and resident safety, nurses were required to administer all medications rather than allowing residents to self-administer. Cross Reference with F689 and F761

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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** Based on observation, interview, clinical record review, and document review, the facility failed to 1) ensure a resident's wound care was completed as ordered for 1 of 31 sampled residents (Resident #56). This deficient practice had the potential to result in a resident's wound worsening, a resident developing an infection in the wound, or causing unnecessary pain for a resident. Findings include: Wound Care Resident #56 Resident #56 was admitted to the facility on [DATE], with diagnoses including unspecified open wound, right foot, subsequent encounter and other acute osteomyelitis, right ankle and foot. On 06/22/2026 at 1:30 PM, the resident verbalized the resident had injured the resident's foot recently. The resident verbalized the resident was not sure what had happened, but the resident's foot had started bleeding. A Nursing Narrative Note for Resident #56, dated 06/09/2026, documented a Certified Nursing Assistant (CNA) had noticed bright, red blood on the floor of the resident's room. The bleeding was from the heel of the resident's right foot. An order for Resident #56, dated 06/10/2026, documented to cleanse the open area to the right heel, apply xeroform followed by an abdominal (ABD) pad and then wrap with a woven gauze bandage (Kerlix) and secure with an elastic bandage (ACE wrap). A care plan for Resident #56, initiated 06/10/2026, documented the resident had an actual alteration in skin related to a right heel wound. Interventions included administering treatments as ordered and monitor for effectiveness. The June 2026 Treatment Administration Record (TAR), documented to cleanse small open area to the right heel, apply xeroform followed by an ABD pad and then wrap with Kerlix and secure with an ACE wrap in the morning every Monday, Wednesday, and Friday. The treatment was documented as completed on Monday 06/22/2026. On 06/23/2026 at 2:57 PM, the Wound Care Licensed Practical Nurse (LPN) verbalized the wound care for the traumatic wound on Resident #56's heel was the responsibility of the floor nurse. The Wound Care LPN verbalized the LPN primarily performed wound care for complex or worsening wounds and minor injuries such as the wound on Resident #56's heel would be the responsibility of the floor nurse assigned to the resident. On 06/23/2026 at 3:17 PM, the floor nurse (LPN2) assigned to Resident #56 verbalized the LPN2 had been assigned to the resident on 06/22/2026. The LPN2 verbalized the LPN had not seen the resident's wound and had not performed wound care on Resident #56 as the Wound Care LPN was managing the resident's wound. On 06/23/2026 at 3:28 PM, the Wound Care LPN confirmed the Wound Care LPN was not performing Resident #56's wound care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Wound Care LPN assessed Resident #56's right heel and confirmed the resident did not have a dressing to the resident's heel. The Wound Care LPN confirmed the wound care had been documented as completed on 06/22/2026, by the floor nurse. On 06/23/2026 at 3:40 PM, the Director of Nursing (DON) verbalized the wound care should not have been documented as complete by the floor nurse unless the nurse had completed the wound care. The DON verbalized it was important to follow wound care orders and document accurately to ensure the resident did not develop an infection and the wound did not worsen. The facility policy titled Skin and Wound Management, dated 02/01/2019, documented each resident with skin breakdown would receive the services and treatment to prevent infection and promote wound healing. A plan of care would also be initiated to address areas of actual skin breakdown. The plan of care would be reviewed and revised as needed. Cross reference with tag F656 and F842

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **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 medications were not left unsecured at residents' bedside for 1 of 31 sampled residents (Resident #6). This deficient practice had the potential to have medications diverted, medications left unsecured, used or ingested by other residents, and lacked verification of unsupervised medication administration resulting in adverse medication outcomes. Findings include:Resident #6 Resident #6 was admitted to the facility on [DATE], and readmitted on [DATE] and 03/27/2026, with diagnoses including hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting right dominant side, major depressive disorder, recurrent, unspecified, and intentional self-harm by other specified means, initial encounter. A Psychiatric Follow Up Progress Note dated 05/14/2026, documented Resident #6 demonstrated concerning medication hoarding behavior by possessing bags of partially decomposed narcotic pills the resident verbalized was saving for transfer to another facility. Resident #6 denied suicidal intent. A Nursing Progress Noted dated 05/26/2026, documented the resident was having issues with hoarding pain pills due to frustration about not having a pain pump. On 06/24/2026 at 8:19 AM, Resident #6 explained there was a Registered Nurse (RN) that would leave the resident's oxycodone and morphine pills with the resident. The resident was able to hoard the pain pills without staff knowledge and wanted to keep the pain pills so if the resident experienced pain and could not get a hold of anyone, the resident could administer the pain pills to themself. On 06/24/2026 at 8:56 AM, the Unit Manager LPN explained a staff member had discovered unsecured medications in the resident's room and reported the unsecured medications to the Unit Manager LPN. The Unit Manager LPN recalled there were a lot of pain pills in the resident's room and approximated to be about 15 pain pills. The Unit Manager LPN spoke to staff and staff had no idea how the resident was able to possess and hoard pain pills. The Unit Manager LPN verbalized all licensed nurses were to take medications into a resident room, make sure the right resident was being administered the medications, inform the resident what medications the resident would be taking, watch the resident swallow the medications, and were not able to leave the resident until the medications were swallowed. On 06/24/2026 at 9:01 AM, the Director of Nursing (DON) explained during the nurse staff meetings, discussion was held with all of the nurses to confirm residents swallow the medications. The DON verbalized if a resident had a history of not swallowing medications, the nurses would check the mouths of residents to ensure medications had been swallowed. On 06/24/2026 at 9:02 AM, the Unit Manager LPN explained the resident had possession of Oxycodone and Morphine pain pills; however, since the incident, the nurses were not administering nor checking successful administration of the resident's medications any differently than prior to the incident. The Unit Manager LPN confirmed the resident's Oxycodone and Morphine pills were unsecured in the facility and accessible to all residents and staff. On 06/25/2026 at 9:16 AM, the DON explained when administering medications, the nurse must ensure the nurse knocks on the resident's room prior to entering, the RN needs to introduce themselves to the resident, make sure the right person is being administered the medications, follow the parameters of administration, and make sure the resident swallows the medications prior to leaving the resident's room. The DON verbalized if a nurse did not ensure a resident took their medications, it could alter a resident's health and cause a negative impact. Failure to do so could result in false monitoring of a medication and false side effects of a medication. There would also be a potential other residents could take the medications not belonging to them and that residents' health could worsen. The facility policy titled Liberalized Medication Administration-Policy & Procedure (Alta), undated, documented the facility was to administer medications to residents in a safe manner but in a way that correlated with daily activities and natural schedules. The facility would properly assess residents and plan care to meet the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's needs. Medications would be administered in a safe manner and per physician orders. The Fundamentals of Nursing, by [NAME] and [NAME], Twelfth Edition, Copyright 2026, Section Medication Administration, documented medications were to be administered per physician orders and to enhance accuracy and resident safety, nurses were required to administer all medications rather than allowing residents to self-administer. Failing to administer medication properly was a medication error Cross Reference with F658, F697, F761

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, clinical record review and document review, the facility failed to ensure a resident's pain was managed with care planned interventions, pain was evaluated per physician orders, and appropriate administration of pain medication for 2 of 31 sampled residents (Resident #71 and #6). This deficient practice had the potential for unrelieved pain, discomfort, and inadequate pain management.Findings include:Resident #71 Resident #71 was admitted to the facility on [DATE], with diagnoses including encounter for orthopedic aftercare following surgical amputation, acquired absence of left leg below knee, difficulty walking, and other reduced mobility. A physician's order dated 06/09/2026, documented acetaminophen oral tablet 500 milligrams (mg), give two tablets (1000 mg) by mouth every eight hours as needed for mild to moderate pain levels of one to five. Resident #71 was administered acetaminophen 1000 mg on the following dates: -06/09/2026 at 8:45 PM, for a pain level of seven. -06/10/2026 at 4:55 AM, for a pain level of six. -06/14/2026 at 9:21 PM, for a pain level of seven. -06/15/2026 at 5:20 AM, for a pain level of seven. -06/15/2026 at 7:15 PM, for a pain level of six. -06/16/2026 at 4:22 AM, for a pain level of six. -06/17/2026 at 1:38 AM, for a pain level of six. The care plan for Resident #71 documented the resident had an amputation (left below knee amputation). Analgesics would be given as ordered by the physician. Pain management monitoring/documenting included frequency, duration, intensity of pain, and phantom pain. Report to physician if medications were not effective. A physician's order dated 06/09/2026, documented oxycodone HCl 10 mg, give one tablet by mouth every six hours as needed for severe pain levels of seven to 10. Resident #71 was administered oxycodone HCl 10 mg on the following dates: -06/11/2026 at 1:00 PM, for a pain level of two. -06/13/2026 at 6:46 PM, for a pain level of six. -06/14/2026 at 12:48 AM, for a pain level of six. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-06/14/2026 at 6:52 AM, for a pain level of six. A physician's order dated 06/13/2026, and discontinued on 06/15/2026, documented oxycodone HCl 10 mg, give one tablet by mouth every six hours as needed for severe pain for pain levels of seven to 10. Resident #71 was administered oxycodone HCl 10 mg on 06/15/2026 at 7:15 PM, for a pain level of six. A physician's order dated 06/15/2026, and discontinued on 06/18/2026, documented oxycodone HCl 10 mg, give one tablet by mouth every four hours as needed for moderate to severe pain levels of seven to 10. Resident #71 was administered oxycodone HCl 10 mg on the following dates: -06/16/2026 at 4:22 AM, for a pain level of six. -06/16/2026 at 9:06 PM, for a pain level of six. -06/17/2026 at 1:36 AM, for a pain level of six. -06/17/2026 at 9:22 PM, for a pain level of six. -06/18/2026 at 5:30 AM, for a pain level of six. -06/18/2026 at 9:34 AM, for a pain level of six. A physician's order dated 06/17/2026, documented oxycodone HCl 10 mg, give one tablet by mouth every four hours as needed for moderate to severe pain levels of five to 10 for fourteen days. Resident #71 was administered oxycodone HCl 10 mg on the following dates: -06/18/2026 at 7:04 PM, for a pain level of two. -06/25/2026 at 11:45 AM, for a pain level of two. The care plan for Resident #71 documented the resident used oxycodone for pain. Interventions were to complete the pain assessment prior to opioid administration and document the effectiveness of the medication. Administer opioid medication (oxycodone) as ordered. On 06/23/2026 at 8:03 AM, Resident #71 explained feeling frequent phantom pain in the area of the newly amputated left leg. The resident expressed being concerned the nursing staff did not understand how phantom pain feels and the pain medications did not always help. On 06/24/2026 at 4:08 PM, the Director of Nursing (DON) confirmed the medications were not administered to Resident #71 appropriately for the pain levels as written in the physician orders. The prescribed oxycodone was ordered for moderate to severe pain and the acetaminophen was ordered for mild to moderate pain. The DON verbalized the expectation of the nursing staff to follow all orders as written by the provider. The DON confirmed a resident should not receive a narcotic pain (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication for a pain level of two and could cause adverse effects such as drowsiness, oversedation, and respiration suppression. The DON communicated acetaminophen was not ordered for moderate to severe pain and would not have effectively controlled Resident #71's pain. On 06/25/2026 at 7:48 AM, a Licensed Practical Nurse (LPN) explained a mild to moderate pain scale was a level of one to five. A moderate to severe pain level was five to 10. The LPN communicated the nursing staff would follow the orders for pain medication as written and the provider would specify if the pain scale was different than the normal parameters. The facility policy titled Pain Assessment and Management, dated 02/01/2019, documented pain would be assessed using a consistent approach and standardized pain assessment. Pain medication would be given as ordered and would be carefully documented. The facility policy titled, Liberalized Medication Administration-Policy and Procedure, dated 02/2023, documented medications would be administered per physician orders. Resident #6 Resident #6 was admitted on [DATE] and readmitted on [DATE] and 03/27/2025 with diagnoses including hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting the right dominant side, major depressive disorder, recurrent, unspecified, and intentional self^harm by other specified means, initial encounter. A Psychiatric Follow^Up Progress Note dated 05/14/2026 documented Resident #6 possessed bags of partially decomposed narcotic pills the resident verbalized were being saved for transfer to another facility. The resident denied suicidal intent. A Nursing Progress Note dated 05/26/2026 documented the resident continued hoarding pain pills due to frustration about not receiving a pain pump. On 06/24/2026 at 8:19 AM, Resident #6 explained a Registered Nurse (RN) would leave oxycodone and morphine pills with the resident and leave the resident's room. The resident verbalized pills were hoarded without staff knowledge and kept so pain could be self^managed if staff were unavailable. A physician's order dated 06/20/2026, documented Morphine Sulfate Extended Release oral tablet, 15 milligram (mg). Give one tablet by mouth three times a day for chronic pain; pain management for 30 days for a diagnosis of chronic pain syndrome. A physician's order dated 06/19/2026, documented Oxycodone Hydrochloride (HCl) oral tablet 10 mg. Give one capsule by mouth two times a day for chronic pain; pain managed for 30 days until finished for a diagnosis of chronic pain syndrome. On 06/24/2026 at 8:56 AM, the Unit Manager LPN explained a staff member discovered unsecured medications in the resident room and reported the finding to the Unit Manager LPN. The Unit Manager LPN recalled approximately 15 pain pills were present. The Unit Manager LPN verbalized staff had no idea how the resident obtained and hoarded pain pills. The Unit Manager LPN verbalized licensed nurses were required to bring medications into the room, confirm correct resident, explain medications, observe ingestion, and remain with the resident until (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

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications were swallowed. The Unit Manager LPN explained the resident was supposed to receive a pain pump months earlier but cancelled the resident's travel due to unforeseen circumstances. The resident was cheeking the pain pills when the nurses would attempt to administer and spit the pills out to hoard after the nurses left the resident's room. The Unit Manager LPN reported the pills appeared wet and discolored. The Unit Manager LPN verbalized nurses were never permitted to leave medications with residents and no staff admitted to leaving medications unattended. On 06/24/2026 at 9:01 AM, the DON verbalized nurses were reminded during meetings to ensure residents swallowed medications. The DON verbalized mouth checks were only performed if a resident had a history of not swallowing medications; however, Resident #6 had no history of cheeking medications prior to the incident. On 06/24/2026 at 9:02 AM, the Unit Manager LPN verbalized Resident #6 possessed oxycodone and morphine. The Unit Manager LPN explained nurses were not administering or monitoring medication ingestion any differently after the incident. The Unit Manager LPN confirmed the resident's oxycodone and morphine pills were unsecured in the facility and accessible to residents and staff. The Unit Manager LPN approximated three days of the resident hoarding pain medications in the resident's room and wondered if the resident had any actual pain throughout the resident's body. The Unit Manager LPN verbalized the Unit Manager LPN often wondered if the pain Resident #6 claimed to have was true and accurate. Resident #6's Pain Evaluations dated 09/18/2025 and 04/28/2026, documented the resident had a pain frequence almost constantly. The pain had an effect on sleep, therapy activities, and day to day activities. On 06/24/2026 at 10:57 AM, the DON explained pain assessments were conducted at admission, every shift, and during medication administration. Pain assessments were also completed quarterly as part of the Minimum Data Set (MDS). The DON verbalized pain discussions occurred during clinical meetings but were not documented in Interdisciplinary Team Meeting (IDT) notes. The DON explained the resident's pain was associated with stroke, chronic low back pain, polyneuropathy, migraines, and chronic pain syndrome. The resident received gabapentin three times daily, methocarbamol every eight hours as needed, oxycodone every four hours as needed, pregabalin twice daily, and morphine extended release three times daily. The DON verbalized pain management was essential for the psychosocial wellˆbeing, Activities of Daily Living (ADL), sleep, and rehabilitation participation for the resident. The DON verbalized nonˆpharmacological interventions were minimal since the resident was cognitive and primarily involved redirection. The DON explained if Resident #6 had not taken the resident's pain pills for three days, the resident would experience high levels of pain and even after administration on the fourth day, the pain pills would likely not be effective in relieving the resident's pain. The DON verbalized Resident #6 experienced pain daily and confirmed it was not appropriate for nurses to suggest a resident was not in pain, as pain was subjective and must be respected, the resident was not administered pail pills according to the physician order, and the resident experienced pain daily. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Pain Assessment and Management, adopted 02/01/2019, documented the pain management program was based on a facility-wide commitment to resident comfort. Staff would be trained on recognizing pain, assessing pain, identifying causes of pain, defining goals and appropriate interventions, implementing pain management strategies, monitoring and modifying approaches, documenting pain, and reporting any significant changes in the residents pain levels. Cross Reference with F658 andF689

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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, clinical record review, and document review, the facility failed to ensure medications were not left at a resident's bedside unattended for 1 of 31 sampled residents (Resident #133). 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 medications. Findings include: Resident #133 Resident #133 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including active primary progressive multiple sclerosis, unspecified severe protein-calorie malnutrition, and fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing. On 06/25/2026 at 8:56 AM, located in Resident #133's room, on a table next to the resident's bed, was a cup of unknown pills. There was not a nurse within line of sight nor in the resident's room. Resident #133 explained the pills were left with the resident by the Registered Nurse (RN). On 06/25/2026 at 9:01 AM, the RN was walking into a resident's room to administer medications to the resident. The RN waited with the resident until all medications were swallowed. On 06/25/2026 at 9:04 AM, the RN explained when administering medications, the RN made sure to have the right resident, right medication, and right dosage. Once confirmed, the RN watched the resident take the medications. The RN explained medications were not to be left with the resident. The RN entered Resident #133's room and confirmed there was a cup of medications, unattended and unsecured, on the resident's side table. The RN verbalized leaving the medications with the resident because there were no controlled medications in the cup and the RN had faith Resident #133 would take the medications. The RN confirmed leaving the medications unattended and out of the line of sight with Resident #133 in the room. The RN did not leave the resident's room verbalizing I have to watch the resident take the medications now. On 06/25/2026 at 9:16 AM, the DON explained when administering medications, the nurse was to ensure the nurse knocks on the resident's room prior to entering, introduce themselves to the resident, ensure the right person was being administered the medications, follow the parameters of administration, and make sure the resident swallows the medications before leaving the resident's room. The DON verbalized if a nurse did not ensure a resident took their medications, it could alter a resident's health and cause a negative impact. Failure to do so could result in false monitoring of a medication and false side effects of a medication. The DON further stated there would also be a potential for other residents to take the medications not prescribed to them which could worsen the residents' health. The Fundamentals of Nursing, by [NAME] and [NAME], Twelfth Edition, Copyright 2026, Section Medication Administration, documented failing to administer medication properly was a medication error. The facility policy titled Liberalized Medication Administration-Policy & Procedure (Alta), revised 02/2023, documented the facility was to administer medications to residents in a safe manner but in a way that correlated with daily activities and natural schedules. The facility would properly assess residents and plan care to meet the resident's needs. Cross Reference with F658.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure 500 and 600 hall satellite resident pantry and refrigerator food and drink items were protected from cross contamination. This deficient practice had the potential to affect residents in 500 and 600 hall by increasing the risk of cross contamination and causing infection and foodborne illnesses.Findings include:On 06/22/2026 at 9:15 AM, three refillable water bottles, one open soda can, one open Red Bull, one open Gatorade and one Starbucks drink which belonged to staff were on the countertop, which is part of the resident food service area in 500 and 600 satellite pantry. The Kitchen Manager confirmed the pantry was meant only for resident's food and drink items and that it could be much cleaner. On 06/23/2026 at 2:13 PM, a Certified Nursing Assistant (CNA) confirmed the 500 and 600 hall pantry were for resident's food and drink items. The CNA confirmed having staff personal drink containers in the pantry room posed the risk of cross contamination. CNA confirmed staff personal drinks were to be stored in the employee break room. On 06/24/2026 at 12:15 PM, the Kitchen Manager confirmed the 500 and 600 hall pantry was for resident's food and drink items. Kitchen Manager confirmed having staff personal drink containers in the pantry room posed the risk of cross contamination. Kitchen Manager confirmed staff personal drinks were to be stored in the employee break room.The facility did not provide a policy related to where staff personal belongings were to be stored.

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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** Based on observation, interview, clinical record review, and document review, the facility failed to ensure a resident's record contained accurate documentation of a resident's wound care for 1 of 31 sampled residents (Resident #56). This deficient practice had the potential to cause a resident's wound to worsen without staff's knowledge and cause a delay in necessary treatment to prevent infection or promote healing.Findings include: Resident #56 Resident #56 was admitted to the facility on [DATE], with diagnoses including unspecified open wound, right foot, subsequent encounter and other acute osteomyelitis, right ankle and foot. On 06/22/2026 at 1:30 PM, the resident verbalized the resident had injured the resident's foot recently. The resident verbalized the resident was not sure what had happened, but the resident's foot had started bleeding. A Nursing Narrative Note for Resident #56, dated 06/09/2026, documented a Certified Nursing Assistant (CNA) had noticed bright, red blood on the floor of the resident's room. The bleeding was from the heel of the resident's right foot. An order for Resident #56, dated 06/10/2026, documented to cleanse the open area to the right heel, apply xeroform followed by an abdominal (ABD) pad and then wrap with a woven gauze bandage (Kerlix) and secure with an elastic bandage (ACE wrap). A care plan for Resident #56, initiated 06/10/2026, documented the resident had an actual alteration in skin related to a right heel wound. Interventions included administering treatments as ordered and monitor for effectiveness. The June 2026 Treatment Administration Record (TAR), documented to cleanse small open area to the right heel, apply xeroform followed by an ABD pad and then wrap with Kerlix and secure with an ACE wrap in the morning every Monday, Wednesday, and Friday. The treatment was documented as completed on Monday 06/22/2026. On 06/23/2026 at 2:57 PM, the Wound Care Licensed Practical Nurse (LPN) verbalized the wound care for the traumatic wound on Resident #56's heel was the responsibility of the floor nurse. The Wound Care LPN verbalized the LPN primarily performed wound care for complex or worsening wounds and minor injuries such as the wound on Resident #56's heel would be the responsibility of the floor nurse assigned to the resident. On 06/23/2026 at 3:17 PM, the floor nurse (LPN2) assigned to Resident #56 verbalized the LPN2 had been assigned to the resident on 06/22/2026. The LPN2 verbalized the LPN had not seen the resident's wound and had not performed wound care on Resident #56 as the Wound Care LPN was managing the resident's wound. On 06/23/2026 at 3:28 PM, the Wound Care LPN confirmed the Wound Care LPN was not performing Resident #56's wound care. The Wound Care LPN assessed Resident #56's right heel and confirmed the resident did not have a dressing to the resident's heel. The Wound Care LPN confirmed the wound care had been documented as completed on 06/22/2026, by the floor nurse. On 06/23/2026 at 3:40 PM, the Director of Nursing (DON) verbalized the wound care should not have been documented as complete by the floor nurse unless the nurse had completed the wound care. The DON verbalized it was important to follow wound care orders and document accurately to ensure the resident did not develop an infection and the wound did not worsen. The facility policy titled Charting and Documentation, adopted 02/01/2019, documented the medical record would facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record would be complete and accurate. Cross reference with tag F684

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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, clinical record review, and document review, the facility failed to ensure staff performed hand hygiene in between glove changes when providing wound care to 1 of 31 sampled residents (Resident #9). This deficient practice had the potential to contaminate a wound and spread infection causing a resident to experience delayed healing or prolonged illness.Findings include: Resident #9 Resident #9 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unspecified open wound, right thigh, subsequent encounter, unspecified open wound, left thigh, subsequent encounter, and pressure ulcer of sacral region, unspecified stage. The wound care orders for Resident #9 documented the following: Cleanse right buttock pressure injury with normal saline solution (NSS), pat dry with gauze, apply Medihoney and collagen particles to the wound bed followed by calcium alginate, apply barrier cream to peri wound and then cover with a silicone dressing daily. The start date was 06/15/2026. On 06/24/2026 at 10:03 AM, the Wound Care Licensed Practical Nurse (LPN) and a Registered Nurse (RN) prepared to perform the wound care for Resident #9. The following was observed. The LPN and RN performed hand hygiene (HH) with an alcohol-based hand rub (ABHR) and donned gloves.The LPN removed the old dressing, removed gloves and donned new gloves, but did not perform HH in between the glove change.The LPN then put a barrier cloth under the resident and removed gloves and donned new gloves but did not perform HH in between the glove change.The LPN then cleansed the wound with NSS and gauze pads and then removed gloves and donned new gloves but did not perform HH in between the glove change.The LPN then patted the wound bed dry with dry gauze and then removed gloves and donned new gloves but did not perform HH in between the glove change.The LPN then applied Medihoney and collagen particles to the wound bed followed by calcium alginate and a silicone dressing. The LPN then removed gloves and donned gloves but did not perform HH in between the glove change.The RN then removed gloves, retrieved a box of gloves from the bathroom and donned new gloves but did not perform HH in between the glove change.The LPN then cleansed the resident's thigh with NSS and patted dry. The LPN then removed gloves and donned new gloves but did not perform HH in between the glove change.The LPN applied collagen particles to the thigh and barrier cream to the peri wound. The LPN then removed gloves and donned new gloves but did not perform HH in between the glove change.The LPN then applied a silicone dressing and removed gloves and donned new gloves before assisting to apply a clean brief to the resident but did not perform HH in between the glove change. On 06/24/2026 at 10:16 AM, the LPN verbalized HH did not need to be performed in between glove changes and performing HH before starting wound care and after completing wound care was acceptable. The LPN confirmed the LPN had not performed HH in between the glove changes. On 06/24/2026 at 10:18 AM, the RN verbalized HH should have been performed in between glove changes. The RN confirmed the RN had not performed HH in between glove changes. On 06/25/2026 at 10:09 AM, the Infection Preventionist verbalized HH should have been performed anytime gloves were removed in order to stop the spread of infection as the soiled dressing could carry microorganisms. The facility policy titled Handwashing/Hand Hygiene, revised 08/2015, documented the facility considered hand hygiene the primary means to prevent the spread of infections. Use of an ABHR or soap and water to wash hands would be used after removing gloves.